



North Sound Accountable Community of Health

Healthier Washington Medicaid Transformation

Implementation Plan Narrative

October 1, 2018

INTRODUCTION	4
North Sound ACH Initiative Portfolio	4
PARTNERING PROVIDER PROJECT ROLES	8
Partnering Provider Example 1: San Juan County	9
Partnering Provider Example 2: Opportunity Council	11
Partnering Provider Example 3: Compass Health	13
Partnering Provider Example 4: Unity Care NW	16
PARTNERING PROVIDER ENGAGEMENT	18
North Sound ACH Partnering Provider Engagement Overview	18
Training or Technical Assistance Resources	19
Engaging Partners with Limited Capacity	20
Cross-ACH Coordination	20
PARTNERING PROVIDER MANAGEMENT	23
Project Implementation Expectations for Partnering Providers	23
How Partners' Implementation Progress Will Be Measured	24
ALIGNMENT WITH OTHER PROGRAMS	27
Project 2A - Bidirectional Integration of Physical and Behavioral Health (required)	28
Project 3A - Addressing the Opioid Crisis (required)	29
Project 2B - Community-Based Care Coordination	29
Project 2C - Transitional Care	31
Project 2D - Diversion Interventions	33
Project 3B - Reproductive and Maternal/Child Health	33
Project 3C - Access to Oral Health Services	35
Project 3D - Chronic Disease Prevention and Control	35
REGIONAL READINESS FOR TRANSITION TO VALUE-BASED CARE	37
REGIONAL READINESS FOR HEALTH INFORMATION TECHNOLOGY (HIT) / HEALTH INFORMATION EXCHANGE (HIE)	39
TECHNICAL ASSISTANCE RESOURCES AND SUPPORT	41
ATTACHMENT A: NORTH SOUND ACH INITIATIVE DESCRIPTIONS	44
ATTACHMENT B: CROSSWALK REQUIRED MILESTONES AND ALTERNATE WORKPLAN FORMAT	48

ACH CONTACT INFORMATION

ACH Name	North Sound ACH
Primary Contact Name	Liz Baxter, Executive Director
Phone Number	(360) 386-5745
Email Address	Liz@NorthSoundACH.org
Secondary Contact Name	Heather McGuinness, Project Manager
Phone Number	(360) 543-8857
Email Address	Heather@NorthSoundACH.org

INTRODUCTION

North Sound ACH Initiative Portfolio

Moving from eight Project Areas to four Initiatives

The North Sound ACH elected to pursue strategies in all eight project areas in the Medicaid Transformation toolkit. As our ACH moved toward implementing these strategies, it became clear there was a significant amount of overlap, both in the populations of focus and in the partners that would be implementing strategies. As a result, the North Sound ACH has folded the strategies from the eight project areas into the following four initiatives: Care Coordination, Care Transformation, Care Integration, and Capacity Building. These initiatives will be referenced throughout this Implementation Plan. Please see Figures 1-3, as well as Attachment A, for a full description of these initiatives and how regional Medicaid Transformation strategies fit into them.

Figure 1. North Sound ACH Medicaid Transformation Initiatives

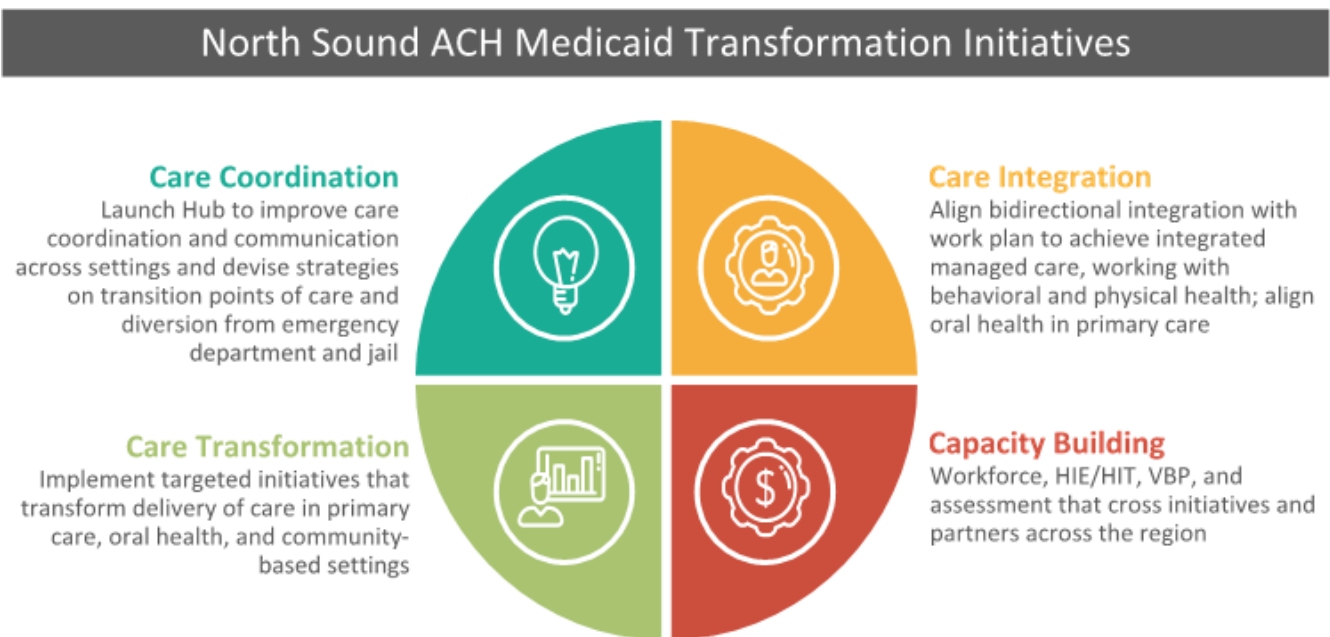


Figure 2. North Sound ACH Medicaid Transformation Initiatives and Project Plan Strategies

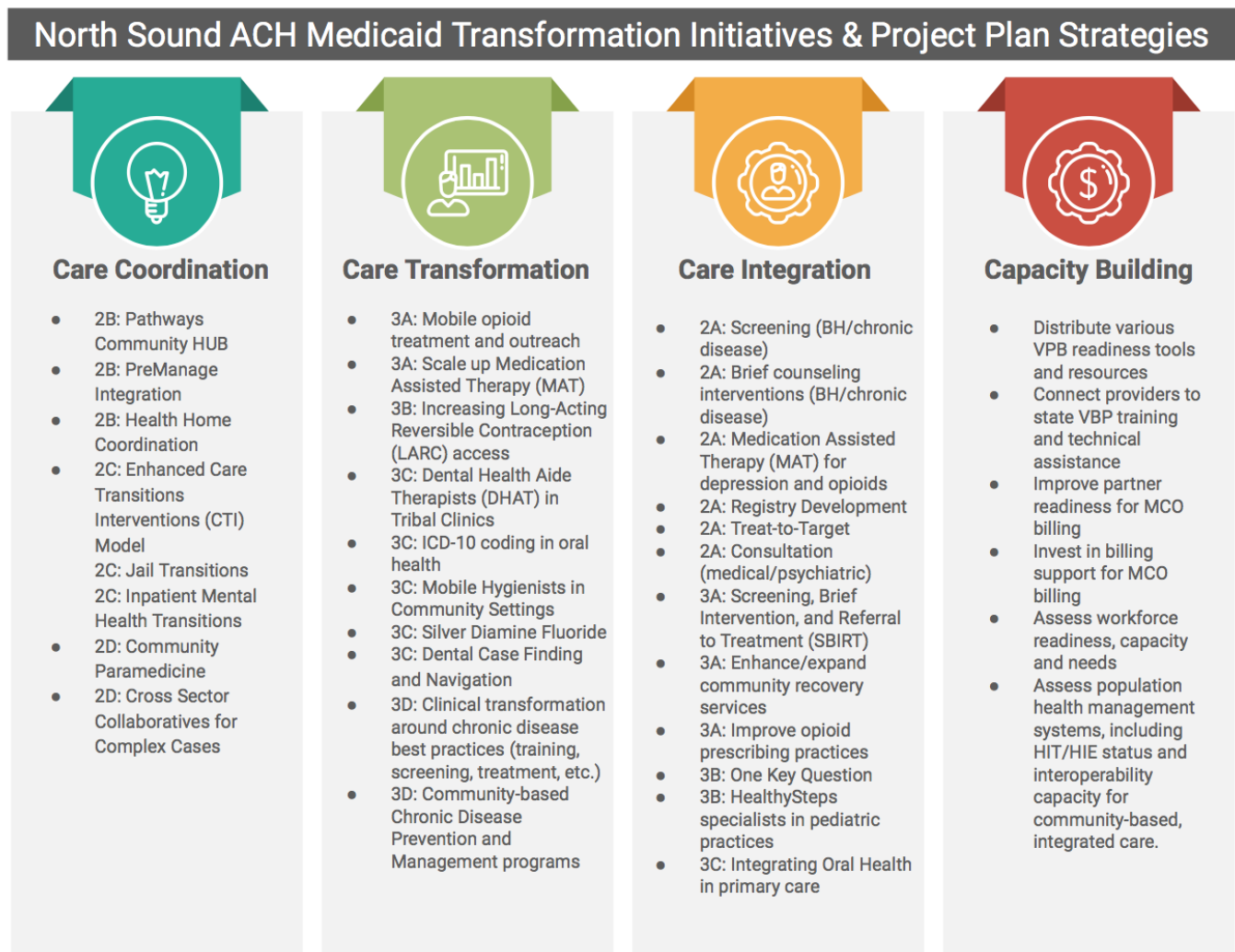
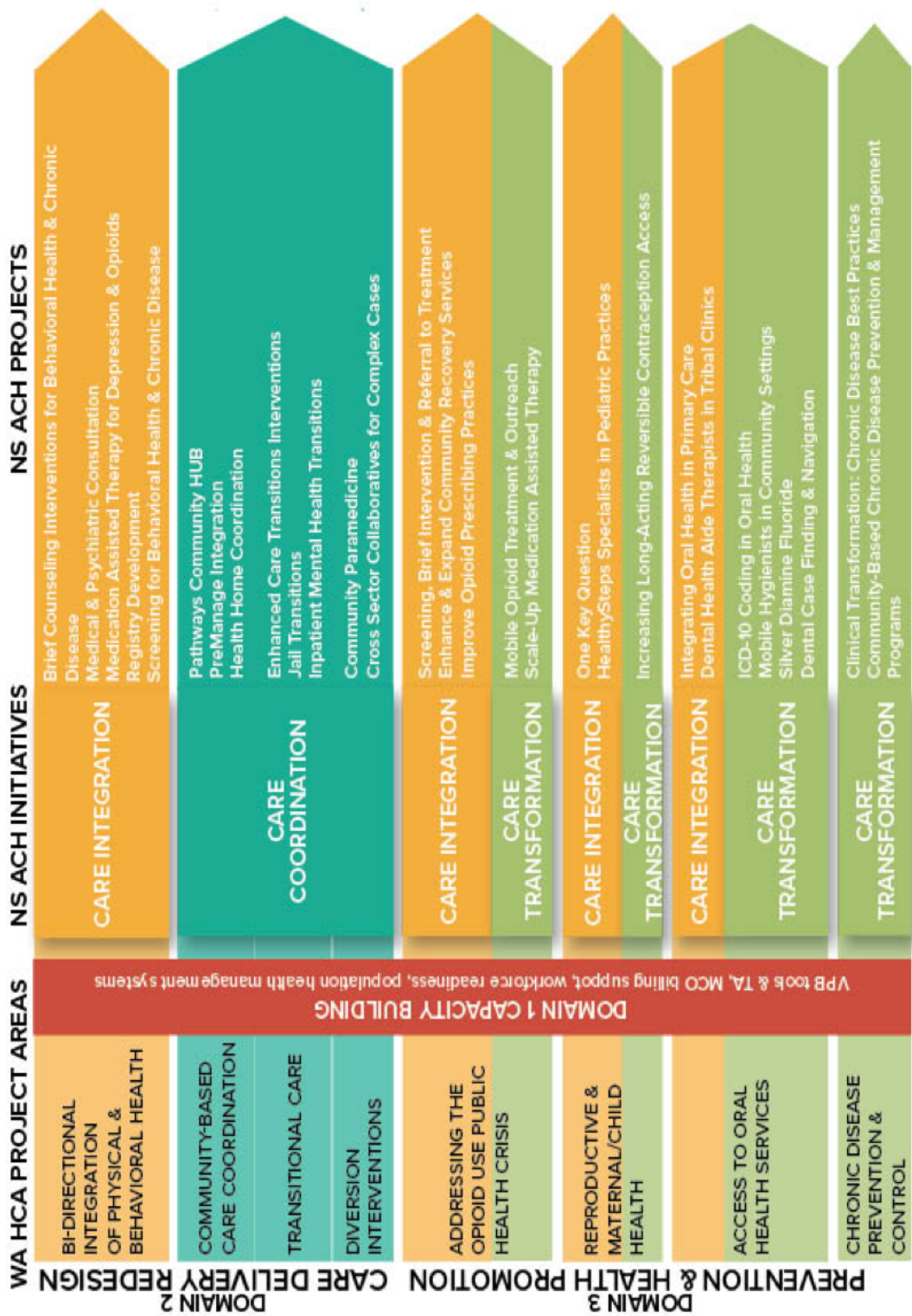


Figure 3. Crosswalk of the Four Initiatives and the Eight Project Areas



See Attachment A for a more detailed narrative description of these initiatives, including their relationship to the eight toolkit project areas and initiative objectives.

Foundational Concept: Targeted Universalism

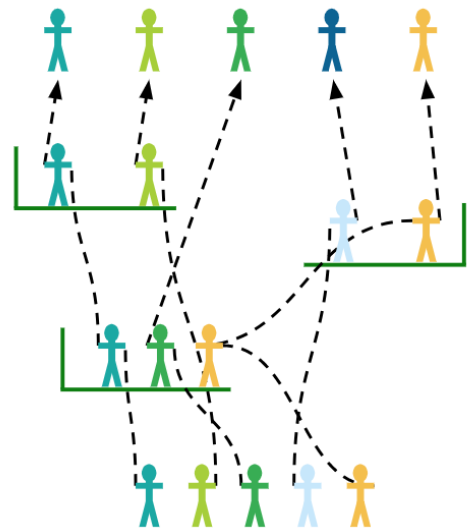
The North Sound ACH has adopted targeted universalism as an operational and communication framework to ensure that health equity is strongly featured throughout the lifespan of project planning and implementation. Universal goals are identified, as well as the obstacles faced by specific groups. Next, one tailors strategies to address each identified barrier. In this way, broad, universal goals are made specific, context-sensitive, and actionable.

Figure 4. Brief Description of Targeted Universalism

Targeted Universalism

Setting universal goals that can be achieved through targeted approaches:

- Step 1- Define a universal goal: Articulate a particular goal based upon a robust understanding and analysis of the problem at hand.
- Step 2- Measure overall population: Assess difference of general population from universal goal.
- Step 3- Measure population segments: Assess particular geographies and population segments divergence from goal.
- Step 4- Understand group based factors: Assess barriers to achieving the goal for each group/geography.
- Step 5- Implement targeted strategies: Craft targeted processes to each group to reach universal goal.



Targeted Universalism, Haas Institute, University of California Berkeley (2018). John A. Powell, Post-Racialism or Targeted Universalism, 86 Denv. U. L. Rev. 785 (2008). Slide from Ben Duncan, Chief Diversity and Equity Officer Multnomah County. Bridging Leadership and Equity: Purpose driven work for Accountable Communities of Health (2017).

PARTNERING PROVIDER PROJECT ROLES

HCA is seeking a more granular understanding of the Medicaid Transformation work being conducted by partnering provider organizations. Imagine the Independent Assessor is conducting a site visit with your partnering providers; how would a partnering provider organization explain its role in the transformation work. What does the provider need to be successful?

Using at least four examples of partnering provider organizations, respond to the questions and provide a detailed description of each organization, and what each organization has committed to do to support of the transformation projects from DY 2, Q3 through DY 3, Q4.

In total, examples must reflect:

- A mix of providers traditionally reimbursed and not traditionally reimbursed by Medicaid.*
- All projects in the ACH's portfolio.*

Responses must cover the following:

- What is the name of the partnering provider organization?*
- What type of entity is the partnering provider organization?*
- In which project/project(s) is the partnering provider organization involved?*
- What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?*
- What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe?*

ACH RESPONSE

Note: The North Sound ACH has not completed the contracting process with partnering providers. We are providing four examples that are a mix of traditionally reimbursed and not traditionally reimbursed by Medicaid for their services.

Partnering Provider Examples:

1. San Juan County
2. Opportunity Council
3. Compass Health
4. Unity Care NW

Partnering Provider Example 1: San Juan County
<p>What is the name of the partnering provider organization?</p> <p>San Juan County Department of Health and Community Services</p>
<p>What type of entity is the partnering provider organization?</p> <p>San Juan County Department of Health and Community Services (San Juan County) is a county entity that provides a wide array of direct public health and behavioral health services, as well as referrals to additional social services available in the community.</p>
<p>In which initiatives/project(s) is the partnering provider organization involved?</p> <p><i>Partner MOUs and final Scopes of Work are in-process. Until then, partner involvement (roles, responsibilities and key steps) is described in terms of participation in planning and development activities and preliminary commitment to initiatives.</i></p> <p><i>North Sound ACH Initiatives</i></p> <ul style="list-style-type: none"> • Care Coordination <ul style="list-style-type: none"> ○ Community HUB ○ Care coordination of complex cases • Care Integration <ul style="list-style-type: none"> ○ Screening for BH and chronic conditions ○ One Key Question ○ Integrating oral Health in primary care • Care Transformation <ul style="list-style-type: none"> ○ Access to LARC ○ Mobile hygienists in community ○ Chronic disease self-management • Capacity Building <ul style="list-style-type: none"> ○ Workforce assessment and readiness ○ Population health management <p><i>Toolkit Project Areas</i></p> <p>2A, 2B, 2D, 3A, 3B, 3C, 3D</p> <p><i>See Attachment A for a detailed description of North Sound ACH initiatives</i></p>
<p>What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?</p> <p><i>Roles and responsibilities -- all partnering providers</i></p> <ul style="list-style-type: none"> • Complete a Change Plan. • Report on progress via an ACH-selected reporting portal. • Identify and/or hire key staff members to carry out initiative implementation.

- Participate in training of evidence-based and emerging models for all initiatives the organization is committing to.
- Articulate staff training/technical advisory needs necessary to implement the identified strategies they are committing to.
- Conduct internal gap analysis of staff capacity to implement the strategies they are committing to and needed technical assistance and training.
- Participate in North Sound ACH Equity Cohort and share learnings within their own organization.
- Participate in series of learnings about the tribes in the North Sound region.
- Collaborate with partners that cross clinical and community sectors.

Roles and responsibilities -- specific to San Juan County

As a Care Coordination Agency (CCA), San Juan County has additional responsibilities

- Contribute to Community HUB's CCA Advisory Committee.
- Develop engagement strategies and action plans for referral partners, HUB providers, incoming CCA cohort, community members, and payers.
- Participate in subcommittees that may be necessary to HUB implementation including finance committee, data integrity committee, CCA supervisors and care coordination staff committee, and HUB care coordinators learning cohorts.
- Act as lead partner for smaller organizations engaged in care coordination strategies in San Juan County.

What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe (DY 2, Q3 through DY 3, Q4)?

San Juan County Health and Human Services (San Juan County) will take the following key steps toward initiative implementation through DY3 Q4

- Identify and/or hire key staff members to carry out initiative implementation and participate in trainings.
- Develop guidelines, policies, and procedures for county-specific care coordination to identify possible overlap, gaps, or best practices to facilitate warm handoff between agencies.
- Participate in training for Public Disclosure, HIPAA, and criminal history sharing.
- Design and utilize a mutually agreed-upon Release of Information (ROI) between partner providers in this project area.
- Document the unique challenges of San Juan County residents and identify possible opportunities or strategies in accessing care.

Specific to the Community HUB San Juan County will:

- Identify a supervisor and 1-2 care coordinators for the CCA who have completed the HUB training.
- Complete training in use of the HUB's software system, Care Coordination Systems.
- Participate in ongoing HUB Advisory Committee meetings.
- Develop a HUB-specific budget for 2019.

Partnering Provider Example 2: Opportunity Council

What is the name of the partnering provider organization?

Opportunity Council

What type of entity is the partnering provider organization?

The Opportunity Council (OC) is a Community Action Agency and social service provider and is community-based nonprofit organization.

The OC provides housing, employment services, financial assistance and education, food assistance, early childhood education, home weatherization, case management, and other community support services. The OC serves Whatcom, Island, and San Juan counties.

In which initiatives/project(s) is the partnering provider organization involved?

Partner MOUs and final Scopes of Work are in-process. Until then, partner involvement (roles, responsibilities and key steps) is described in terms of participation in planning and development activities and preliminary commitment to initiatives.

North Sound ACH Initiatives

- Care Coordination
 - Transition from inpatient hospital, BH and jail settings
 - Care coordination of complex cases
- Care Transformation
 - Mobile opioid treatment and outreach
 - Chronic disease self-management
- Capacity Building
 - Workforce assessment and readiness
 - Population health management and interoperability with CBO systems

Toolkit Project Areas

2B, 2C, 2D, 3A, 3C, 3D

See Attachment A for a detailed description of North Sound ACH initiatives.

What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 (Fall 2018) through DY 3, Q4 (December 2019)?

Roles and responsibilities -- all partnering providers

- Complete a Change Plan.
- Report on progress via an ACH-selected reporting portal.
- Identify and/or hire key staff members to carry out initiative implementation.
- Participate in training of evidence-based and emerging models for all initiatives the organization is committing to.
- Articulate staff training/technical advisory needs necessary to implement the identified strategies they are committing to.
- Conduct internal gap analysis of staff capacity to implement the strategies they are committing to and needed technical assistance and training.

- Participate in North Sound ACH Equity Cohort and share learnings within their own organization.
- Participate in series of learnings about the tribes in the North Sound region.
- Collaborate with partners that cross clinical and community sectors.

Roles and responsibilities -- specific to The Opportunity Council

The Opportunity Council has expressed interest in additional roles and responsibilities from DY 2, Q3 to DY 3, Q4

- Maintain region-wide resource lists, up-to-date information on social service programs, and information on how to access and refer to services.
- Play a connector role for the North Sound ACH and its partners to Initiative 3, Foundational Community Supports.
- Convene Coordinated Entry programs region-wide to enhance communication between clinical and community providers.
- Play a lead role in education across the region related to children with asthma, through learnings from their Healthy Homes project, which includes home education and weatherization repair.
- Play a leadership role in educating partners about how access to housing works in the region.

What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that time frame (DY 2, Q3 (Fall 2018) through DY 3, Q4 (December 2019))?

The Opportunity Council will take the following key steps toward initiative implementation through DY3 Q4

- Identify and/or hire key staff members to carry out initiative implementation.
- Develop guidelines, policies, and procedures to identify possible overlap, gaps, or best practices to facilitate warm handoff between agencies.
- Identify staff members to participate in training of evidence-based and emerging models for all initiatives they are committing to.
- Embed staff hired under Initiative 3 in the GRACE project (cross-sector care coordination for high utilizers).
- Co-locate supportive employment/housing staff within clinical settings.
- Train partners on Coordinated Entry (how access to housing and employment services work).
- Conduct internal gap analysis of staff capacity to implement the strategies they are committing to. Articulate staff training/technical advisory needs necessary to implement the identified strategies they are committing to.
- Participate in trainings for Public Disclosure, HIPAA, and criminal history sharing.
- Design and utilize a mutually agreed-upon Release of Information (ROI) between partner providers.
- Work with ACH partners from inpatient and substance use disorder treatment facilities in the region to document and compare service policies and procedures and identify collaboration opportunities or strategies.
- Participate in regional initiatives on HIT, ROI, and HIE exchange between jails, counties, EMS, and other first responder agencies to identify concerns and challenges related to HIE and data sharing.
- Identify opportunities to collaborate with local and regional services to improve outcomes and reduce barriers to hospital discharge and post-hospital success.

Partnering Provider Example 3: Compass Health
<p>What is the name of the partnering provider organization?</p> <p>Compass Health</p>
<p>What type of entity is the partnering provider organization?</p> <p>Behavioral Health Agency, nonprofit</p>
<p>In which initiatives/project(s) is the partnering provider organization involved?</p> <p><i>Partner MOUs and final Scopes of Work are in-process. Until then, partner involvement (roles, responsibilities and key steps) is described in terms of participation in planning and development activities and preliminary commitment to initiatives.</i></p> <p>North Sound ACH Initiatives</p> <ul style="list-style-type: none"> • Care Coordination <ul style="list-style-type: none"> ○ Community HUB as a CCA ○ Care coordination of complex cases • Care Transformation <ul style="list-style-type: none"> ○ Clinical integration with chronic disease best practices • Care Integration <ul style="list-style-type: none"> ○ Screening, counseling for BH ○ MAT for depression and opioids ○ Develop registries to track BH and PH conditions • Capacity Building <ul style="list-style-type: none"> ○ Workforce assessment and readiness ○ Population health management and interoperability with CBO systems ○ Readiness for MCO billing <p>Toolkit Project Areas</p> <p>2A, 2C, 2D, 3A, 3B, 3C, 3D</p> <p><i>See Attachment A for a detailed description of North Sound ACH initiatives</i></p>
<p>What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?</p> <p>Roles and responsibilities -- all partnering providers</p> <ul style="list-style-type: none"> • Complete a Change Plan. • Report on progress via an ACH-selected reporting portal. • Identify and/or hire key staff members to carry out initiative implementation. • Participate in training of evidence-based and emerging models for all initiatives the organization is committing to. • Articulate staff training/technical advisory needs necessary to implement the identified strategies they are committing to.

- Conduct internal gap analysis of staff capacity to implement the strategies they are committing to and needed technical assistance and training.
- Participate in North Sound ACH Equity Cohort and share learnings within their own organization.
- Participate in series of learnings about the tribes in the North Sound region.
- Collaborate with partners that cross clinical and community sectors.

Roles and responsibilities -- specific to Compass Health

Compass Health has additional responsibilities because of its selection as a Care Coordination Agency (CCA), and as a BHA in the transition to Integrated Managed Care, including:

- Contribute to Community HUB's CCA Advisory Committee
- Develop engagement strategies and action plans for referral partners, HUB providers, incoming CCA cohort, community members, and payers.
- Participate in subcommittees that may be necessary to HUB implementation including finance committee, data integrity committee, CCA supervisors and care coordination staff committee, and HUB care coordinators learning cohorts.
- Assess readiness (staff and billing/IT infrastructure) for MCO billing by end of DY 2, Q4

What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe (DY 2, Q3 through DY 3, Q4)?

Compass Health will take the following key steps toward initiative implementation through DY3 Q4:

- Identify and/or hire key staff members to carry out initiative implementation.
- Develop guidelines, policies, and procedures to identify possible overlap, gaps, or best practice to facilitate warm handoff between agencies.
- Identify staff to participate in training of evidence-based and emerging models for all initiatives they are committing to.
- Conduct internal gap analysis of staff capacity to implement the strategies they are committing to.
- Articulate staff training/technical advisory needs necessary to implement the identified strategies they are committing to.
- Maintain and expand post-discharge care management for patients recently discharged from inpatient mental health facilities.
- Implement use of PMP.
- Implement PreManage.
- Train on:
 - Use of medication-assisted therapy
 - Integration of One Key Question and reproductive health best practices
 - Strategies to integrate oral health
- Participate in training for Public Disclosure, HIPAA, and criminal history sharing.
- Design and utilize a mutually agreed-upon Release of Information (ROI) between partner providers in this project area.
- Work with ACH partners from inpatient and substance use disorder treatment facilities in the region to document and compare service policies and procedures and identify collaboration opportunities or strategies.

- Participate in regional initiatives on HIT, ROI, and HIE exchange between jails, counties, EMS, and other first responder agencies to identify concerns and challenges related to HIE and data sharing.
- Identify a supervisor and 1-2 care coordinators for the CCA who have completed the HUB training.
- Complete training in use of the HUB's software system, Care Coordination Systems.
- Participate in ongoing HUB Advisory Committee meetings.
- Develop a HUB-specific budget for 2019.

Partnering Provider Example 4: Unity Care NW

What is the name of the partnering provider organization?

Unity Care NW

What type of entity is the partnering provider organization?

Federally Qualified Health Center

In which initiatives/project(s) is the partnering provider organization involved?

Partner MOUs and final Scopes of Work are in-process. Until then, partner involvement (roles, responsibilities and key steps) is described in terms of participation in planning and development activities and preliminary commitment to initiatives.

North Sound ACH Initiatives

- Care Coordination
 - PreManage integration
 - Jail, inpatient BH transitions
 - Care coordination of complex cases
- Care Transformation
 - LARC
 - Dental case finding and navigation
 - Chronic disease self-management
- Care Integration
 - Screening for BH and chronic disease
 - Brief counseling interventions
 - Improve opioid prescribing practices
 - Integrate oral health in primary care
- Capacity Building
 - Workforce assessment and readiness
 - Population health management and interoperability with CBO systems

Toolkit Project Areas

2A, 2C, 2D, 3A, 3B, 3C, 3D

See Attachment A for a detailed description of North Sound ACH initiatives

What are the roles and responsibilities of the partnering provider organization from DY 2, Q3 through DY 3, Q4?

Roles and responsibilities -- all partnering providers

- Complete a Change Plan.
- Report on progress via an ACH-selected reporting portal.
- Either lead or partner in project area or strategy area collaborative groups.
- Identify and/or hire key staff members to carry out initiative implementation.

- Develop guidelines, policies, and procedures in order to identify possible overlap, gaps, or best practices to facilitate warm handoff between agencies.
- Have identified staff members participate in training of evidence-based and emerging models for all initiatives the organization is committing to.
- Articulate staff training/technical advisory needs necessary to implement the identified strategies they are committing to.
- Conduct internal gap analysis of staff awareness of and capacity to implement the strategies they are committing to.
- Participate in North Sound ACH Equity Cohort (made up of ACH partners and community) members to lead health equity efforts in the region and share these learnings within their own organization.
- Participate in series of learnings about the tribes in the North Sound region.
- Collaborate with partners that cross clinical and community sectors.

What key steps will the partnering provider organization take to implement projects (e.g., hiring of staff, training or re-training staff, development of policies and procedures to ensure warm hand-offs occur, acquiring and implementing needed interoperable HIT/HIE tools) within that timeframe (DY 2, Q3 through DY 3, Q4)?

Unity Care NW will take the following key steps toward initiative implementation through DY3 Q4:

- Identify and/or hire key staff members to carry out initiative implementation.
- Develop guidelines, policies, and procedures to identify possible overlap, gaps, or best practices to facilitate warm handoff between agencies.
- Identify staff members to participate in training of evidence-based and emerging models for all initiatives they are committing to.
- Articulate staff training/technical advisory needs necessary to implement the identified strategies they are committing to.
- Conduct internal gap analysis of staff capacity to implement the strategies they are committing to.
- Maintain and expand post-discharge care management for patients recently discharged from inpatient mental health facilities.
- Implement use of PMP.
- Implement PreManage.
- Attend trainings as needed on:
 - Use of medication-assisted therapy
 - Integration of One Key Question and reproductive health best practices
 - Strategies to integrate oral health
- Participate in efforts to connect diversion and transitions efforts into community care coordination.
- Participate in training for Public Disclosure, HIPAA, and criminal history sharing.
- Design and utilize a mutually agreed-upon Release of Information (ROI) between partner providers in this project area.
- Work with ACH partners from inpatient and substance use disorder treatment facilities in the region to document and compare service policies and procedures and identify collaboration opportunities or strategies.
- Participate in regional initiatives on HIT, ROI, and HIE exchange between jails, counties, EMS, and other first responder agencies to identify concerns and challenges related to HIE and data sharing.

PARTNERING PROVIDER ENGAGEMENT

Explain how the ACH supports partnering providers in project implementation from DY 2, Q3 through DY 3, Q4.

Responses must cover the following:

- *What training and/or technical assistance resources is the ACH facilitating or providing to support partnering providers in implementation from DY 2, Q3 through DY 3, Q4?*
- *How is training and/or technical assistance resources being delivered within that timeframe (DY 2, Q3 through DY 3, Q4)?*
- *How is the ACH engaging smaller, partnering providers and community-based organizations with limited capacity?*
- *What activities and processes are coordinated/streamlined by the ACHs to minimize administrative burden on partnering providers (e.g., coordination of partnering provider contracts/MOUs)?*
- *How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?*

ACH RESPONSE

North Sound ACH Partnering Provider Engagement Overview

During the Implementation Stage (DY 2, Q3 through DY3, Q4), the North Sound ACH will support partnering providers in project implementation in the following ways:

- All partners will be required to complete change plans, which will detail specific implementation activities and tactics for each partner, identify how they will be collaborating with other partners, and provide a “road map” for their participation in the Medicaid Transformation Project. North Sound ACH staff will provide orientation and guidance about the process for completing these change plans. This process will happen in DY 2, Q3 and Q4.
- The North Sound ACH will be providing or facilitating training and technical assistance in how to participate in an online reporting portal called CSI, which will be used to track partner progress during the implementation stage and beyond.
- The North Sound ACH will be facilitating collaboration between partners, especially across sectors and counties, by providing or facilitating training and technical assistance resources on setting up formalized partnership, information sharing, and more.
- The North Sound ACH will be providing or facilitating trainings and technical assistance in the selected evidence-based strategies and models of care, as well as in the practicalities of project implementation, as described below.
- The North Sound ACH will be providing or facilitating training and capacity building in quality improvement, population health management, care coordination, cultural competency, and health equity.

The following sections describe in further detail how the North Sound ACH will be supporting partners through training or technical assistance resources, engaging partners with limited capacity, and collaborating across ACHs to support shared partners.

Training or Technical Assistance Resources

What training and/or technical assistance resources is the ACH facilitating or providing to support partnering providers in implementation from DY 2, Q3 through DY 3, Q4?

The North Sound ACH has identified key training and/or technical assistance resources to support partnering providers in implementation from DY 2, Q3 through DY3, Q4. This list is not exhaustive, as partnering providers will identify other needs during submission of their change plans.

- The North Sound ACH will partner with **Upstream USA** to provide training on pregnancy intention screening tools (One Key Question), Long-Acting Reversible Contraception (LARC) counseling and insertion, and practice transformation for reducing unintended pregnancy.
- **Six Building Blocks** model to address opioid use disorder.
- **Arcora Foundation** will provide technical assistance for oral health in primary care and ICD-10 coding.
- **Southcentral Foundation** will provide training on the Nuka Model, which encompasses elements of team-based care, integration of physical, oral and behavioral health services, cultural appropriateness and patient-centered care.
- MCO billing training for CBOs on chronic disease.
- Coaching in quality improvement, population health management, billing processes, referral tracking, and other processes of care.
- Collaborative Care Model - **UW AIMS Center**
- **Haas Institute** to lead work on embedding health equity, including implicit bias, structural racism.
- **Children of the Setting Sun** will lead trainings on tribal governance, sovereignty, history and assets.
- **Qualis Health**, especially its practice transformation coaches

In addition, the North Sound ACH is working collaboratively with other ACHs to identify common training needs and potential trainers in the following areas, with a goal to leverage local experts who can share best practices and success strategies in these areas.

- Jail transitions services
- Acute care transitions
- Inpatient psychiatric transitions
- Care transitions intervention (CTI) model
- Community paramedicine
- BH/PH Integration models
- Adverse childhood experiences (ACEs)
- Trauma-informed care
- Population health management strategies
- Using, understanding, and sharing data
- Quality improvement (QI) systems for internally monitoring implementation activities and addressing barriers to implementation.
 - For partners with existing infrastructure, key QI contacts will be identified and the ACH will facilitate access to those QI resources
 - For partners without existing QI infrastructure, foundational trainings in QI principles, (i.e., use of the IHI model for improvement) will be provided.

A specific training curriculum is in place for the North Sound Community HUB's care coordination agency (CCA) partners, including:

- Introduction to the Pathways model and use of tools, resources, checklists, and software
- Roles and challenges for CHWs and their supervisors

How training and/or technical assistance resources are being delivered within that timeframe (DY 2, Q3 through DY 3, Q4)?

Trainings and/or technical assistance resources will be delivered in a variety of ways, as mentioned above, some jointly with other ACHs:

- Large session trainings/workshops delivered onsite in the North Sound region
- Smaller in-person training sessions
- On-site technical assistance or presentations at team meetings or other convenings within organizations (to avoid scheduling “one more meeting”)
- Web-based live trainings
- Recorded webinars available online
- Sharing journal articles and other online/print resources
- Use of transformation coaches to provide 1:1 technical assistance
- Where possible, include perspective of patient/consumer as part of training
- Use of train-the-trainer models
- Peer learning
- Site visits to partners for on-site learning of best practices
- “Office Hours” model, where experts are available at set times to answer questions and provide technical assistance

Engaging Partners with Limited Capacity

How is the ACH engaging smaller, partnering providers and community-based organizations with limited capacity?

Our region has experience in finding creative ways to engage smaller partnering providers and community-based organizations with limited capacity. One county in the North Sound region is only accessible by ferry, so the question of access and capacity is always top of mind. For smaller partner organizations and those with limited capacity, we are using and plan to use several strategies:

- All trainings will be available remotely, using tools such as UberConference service, Zoom, and GoToWebinar.
- Partners will be polled extensively to find times that will work for multiple partners.
- In-person meetings will be centrally located and work within scheduled ferry arrival/departure times.
- Smaller providers will be offered and provided payment to allow for loss of earnings while attending key meetings.

Cross-ACH Coordination

What activities and processes are coordinated/streamlined by the ACHs to minimize administrative burden on partnering providers who are participating in Transformation Projects with more than one ACH (e.g., coordination of partnering provider contracts/MOUs)?

Activities and processes are coordinated and streamlined in order to minimize administrative burden on providers who operate in more than one ACH region.

North Sound ACH participates in a five-ACH collaborative managed by the Center for Evidence-based Policy (Center) at Oregon Health & Science University (OHSU). The OHSU team convenes regular calls and in-person meetings with the participating ACHs. Agendas are developed collaboratively. The focus of the collaborative is on identifying and sharing best practices, pooling resources, providing mutual feedback, developing cooperative strategies, and coordinating efforts wherever possible. The following are some activities that have occurred:

- Joint engagement with vendors to pursue economies of scale and increase effectiveness or impact through coordination
- A report and crosswalk that distill the funds flow and financial management approaches adopted by all ACHs. The information was derived from Center-led interviews with each of the nine ACHs.
- Compiling and sharing best practices. Topics have included the social determinants of health, consumer/beneficiary engagement, bi-directional integration, contracting with behavioral health providers, internal staffing, evaluation and metrics, reporting requirements for CBOs, investing in the community, and health equity.
- A planned workshop dedicated to better understanding ACH successes and challenges pertaining to stakeholder outreach and engagement, provider payments, target populations, and evaluation. This sharing of information has already been critical in informing the ACHs on best approaches for managing pace, scope, and scaling.
- A planned sustainability workgroup that will bring together the participating ACHs and their regions' MCOs, as well as other potential payers. The goal is to coordinate how the ACHs can establish a shared pathway to future MCO payments based on the identification and performance of key, agreed-upon metrics.
- Development of a shared decision tree for vetting and responding to vendor inquiries, with the goal of coordinating between ACHs whenever there is an advantage to doing so.

In addition, all nine ACHs participate in three cross-ACH activities:

- Monthly in-person meeting with ACH Directors, focused on high level integration, learning and sharing approaches to partners and stakeholders;
- Weekly ACH phone call, focused on approaches and strategies with state partners and key stakeholders; and
- Project-focused call with team members from all nine ACHs to discuss approaches to projects, initiatives, strategies and partners.

Activities and processes that have been discussed and shared across ACHs with partners include:

- Coordinating language in change plans. For example, North Sound is building on templates used by North Central and Olympic ACHs.
- Working across ACHs together with HCA and IGT contributors to coordinate workforce strategies, VBP approaches, and population health alignment approaches for Providence Health and Services, PeaceHealth, SeaMar, and Compass Health—the primary partners identified so far that cross multiple ACHs.
- Three ACHs are cooperating on use of a reporting portal (CSI) to align reporting across ACHs, especially for partners that cross ACH boundaries, and three additional ACHs are considering using that vendor.
- Selection of the CCS platform for the Care Coordination HUB, consistent with other ACHs implementing the Pathways model.

- Cross-ACH discussion with MCOs intending to leverage statewide consistency in approaches to sustainability strategies.
- Cross-ACH meetings with partners that cross ACH boundaries, to identify opportunities to minimize administrative burden, beginning with in-person and teleconference meetings with 1) Providence Health and Services, which operates in 5 ACH regions; and 2) Care Coordination Systems, which is being used in six ACH regions.

How is the ACH coordinating with other ACHs in engaging partnering providers that are participating in project activities in more than one ACH?

The North Sound ACH is coordinating with other ACHs in engaging partnering providers who participate in projects in more than one ACH. We use several key strategies:

- In-person meetings with most or all ACHs
- Conference calls with most or all ACHs
- In-person meetings one-on-one with partnering provider and an individual ACH
- Invitation for partnering provider to join one of the weekly ACH calls or the monthly in-person ACH director's meeting.

During 2018, coordinated partnering provider engagement activities across ACHs focused largely on implementation planning and how to successfully engage larger providers that are working across ACHs. ACHs identified barriers to participation for shared providers, as well ways in which each ACH has included these shared providers in planning activities.

Cross-collaboration opportunities are discussed during weekly cross-ACH phone calls with directors and in monthly in-person ACH leadership meetings. Partners who cross ACHs are often invited to these monthly meetings. To date, the five MCOs, UW, Association of WA Public Hospital Districts, Washington State Hospital Association, CMT and legislative leadership have joined the ACH in-person meetings.

Cross-ACH conference calls and meetings have also taken place with CCS, Foundation for a Healthy Generation, and the Department of Health related to Pathways implementation strategies.

ACH directors and shared partnering providers have participated in our cross-ACH discussions and strategizing meetings, including:

- Providence Health System
- Collective Medical Technologies
- Care Coordination Systems
- Foundation for Healthy Generations
- Washington State Hospital Association (WSHA)
- University of Washington
- Association of Washington Public Hospital Districts
- Healthier Washington Practice Transformation Support Hub

Future cross-ACH coordination will include additional partners that cross ACH boundaries as they are identified via the Financial Executor Portal, including PeaceHealth, SeaMar and Compass Health.

PARTNERING PROVIDER MANAGEMENT

Explain how the ACH ensures partnering providers are driving forward project implementation from DY 2, Q3 through DY 3, Q4.

Responses must address both traditional and non-traditional Medicaid providers and cover the following:

- *What are the ACH's project implementation expectations for its partnering providers from DY 2, Q3 through DY 3, Q4?*
- *What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?*
- *What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?*
- *How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?*

ACH RESPONSE

The North Sound ACH will ensure that partnering providers are driving toward project implementation during the implementation stage (DY 2, Q3 through DY 3, Q4) by providing clear and consistent communication on the process for completing change plans and how progress will be measured. The ACH will also facilitate or directly provide training and technical assistance that increases partners' capacity to meet their goals, with particular attention to addressing partners' self-identified gaps and needs.

Project Implementation Expectations for Partnering Providers

What are the ACH's project implementation expectations for its partnering providers from DY 2, Q3 through DY 3, Q4?

Between DY 2, Q3 through DY 3, Q4, the North Sound ACH's project implementation expectations for partnering providers include:

- Attendance at a two-day initial ACH partner retreat in August 2018, at which partners learned about and worked on North Sound ACH initiatives and strategies, contributed to the Regional Implementation Plan deliverable, and were introduced to other 2018 partners.
- Submission of initial partner application, partner self-assessment, and change plans, which indicate the partner's specific commitments.
- Execute signed agreements between the ACH and the partnering provider.
- Report on progress via an ACH-selected reporting portal.
- Identify and/or hire key staff members to carry out initiative implementation.
- Participate in training on evidence-based and emerging models for all initiatives the organization is committing to.
- Identify staff training and/or technical advisory needs necessary to implement the identified strategies they are committing to, including any gaps in staff capacity.
- Participate in North Sound ACH Equity Cohort and share learnings within their own organization.
- Participate in a series of learnings about the tribes in the North Sound region.
- Collaborate with partners that cross clinical and community sectors.
- Maintain internal continuous quality improvement processes.

- Report on implementation progress in the CSI Solutions reporting portal, including status updates, process measures, and clinical quality measures as appropriate.
- Host site visits for the ACH team.
- Specific to the Community HUB, CCAs will:
 - Contribute to Community HUB's CCA Advisory Committee
 - Develop engagement strategies and action plans for referral partners, HUB providers, incoming CCA cohort, community members, and payers.
 - Participate in subcommittees that may be necessary to HUB implementation including finance committee, data integrity committee, CCA supervisors and care coordination staff committee, and HUB care coordinators learning cohorts.

How Partners' Implementation Progress Will Be Measured

What are the key indicators used by the ACH to measure implementation progress by partnering providers within that timeframe?

North Sound ACH will measure progress of partnering providers during implementation by tracking their progress on commitments made in change plans (change plans). Partnering providers will regularly report progress in an online reporting portal hosted by CSI Solutions, and ACH teams will conduct site visits to partners, meeting with leadership and partner implementation team members.

Partner commitments made in their change plans will be the key indicators used by the North Sound ACH to measure their implementation progress within the period of DY2, Q3 and DY 3, Q4.

The CSI portal allows partners to update the status of strategies selected in their change plans and provide documentation of completed steps and submit intermediate measures such as process measures and clinical quality measures. These intermediate measures at the organization or site level will allow for real-time tracking of implementation.

The North Sound ACH will regularly review metrics and assess implementation delays or gaps in performance that require changes or improvements, primarily through reports from the CSI Portal, but also from in-person contacts from partnering providers. Additionally, the ACH will track performance data such as hospital admission, ED utilization, and immunization status using population health management technologies such as CMT's EDIE/PreManage platform, immunization registries, syndromic surveillance, and third-party registries. These platforms can provide a picture of regional performance on some monitoring and continuous measures with a delay as small as 24 hours.

While traditional Medicaid providers will submit clinical quality measures reported out of their EHRs or through contracted third-party reporting mechanisms, the North Sound ACH recognizes that non-traditional Medicaid providers often do not have automated or customizable reporting systems with which to compile measures or reports. The ACH will work with non-traditional Medicaid providers to identify existing monitoring and reporting systems that can be leveraged to report indicators of implementation progress, which could include electronic client record systems for community service programs and public health databases.

For non-traditional Medicaid providers, the North Sound ACH anticipates a need to have alternate key indicators. This discussion is happening through a multi-ACH partnership with the Center for Evidence Based Policy noted at the top of page 21. We will leverage the experience of partners in other ACHs as well as our own to identify key

progress indicators for non-clinical providers. The North Sound ACH's Program Council will provide a sounding board for our approaches, as it includes clinical and community-based providers.

What specific processes and tools (e.g., reports, site visits) does the ACH use to assess partners against these key implementation progress indicators?

The North Sound ACH will use a set of tools and processes to assess partners against key implementation progress indicators:

- Completed individual change plans will be uploaded into the CSI reporting portal, also being used by North Central and Olympic ACHs.
- The partnering providers will enter their progress directly into the CSI Portal, which will be monitored by North Sound ACH project managers.
- Site visits will be carried out at least quarterly to support direct questions and feedback with partnering providers.
- Surveys will be developed for some reporting that may not be included in the reporting portal, such as attendance at ACH trainings or meetings.
- Partners will be asked to provide documentation of their process and progress, by providing copies of guidelines, staffing plans, training materials, etc.

For partners who are also CCAs, specific milestones must be documented, such as training, completion of budget and pro forma, collaboration on development of HUB policies and procedures, and participation in partner and community engagement. The HUB Director will conduct site visits to meet with CCA leaders, care coordinators, and supervisors to assess fidelity to the Community HUB model.

Plan for Partner Support if Implementation Progress is Delayed

How will the ACH support its partnering providers (e.g., provide technical assistance) if implementation progress to meet required project milestones is delayed?

If implementation is impeded, the North Sound ACH is prepared to help its partnering providers to address barriers in several ways:

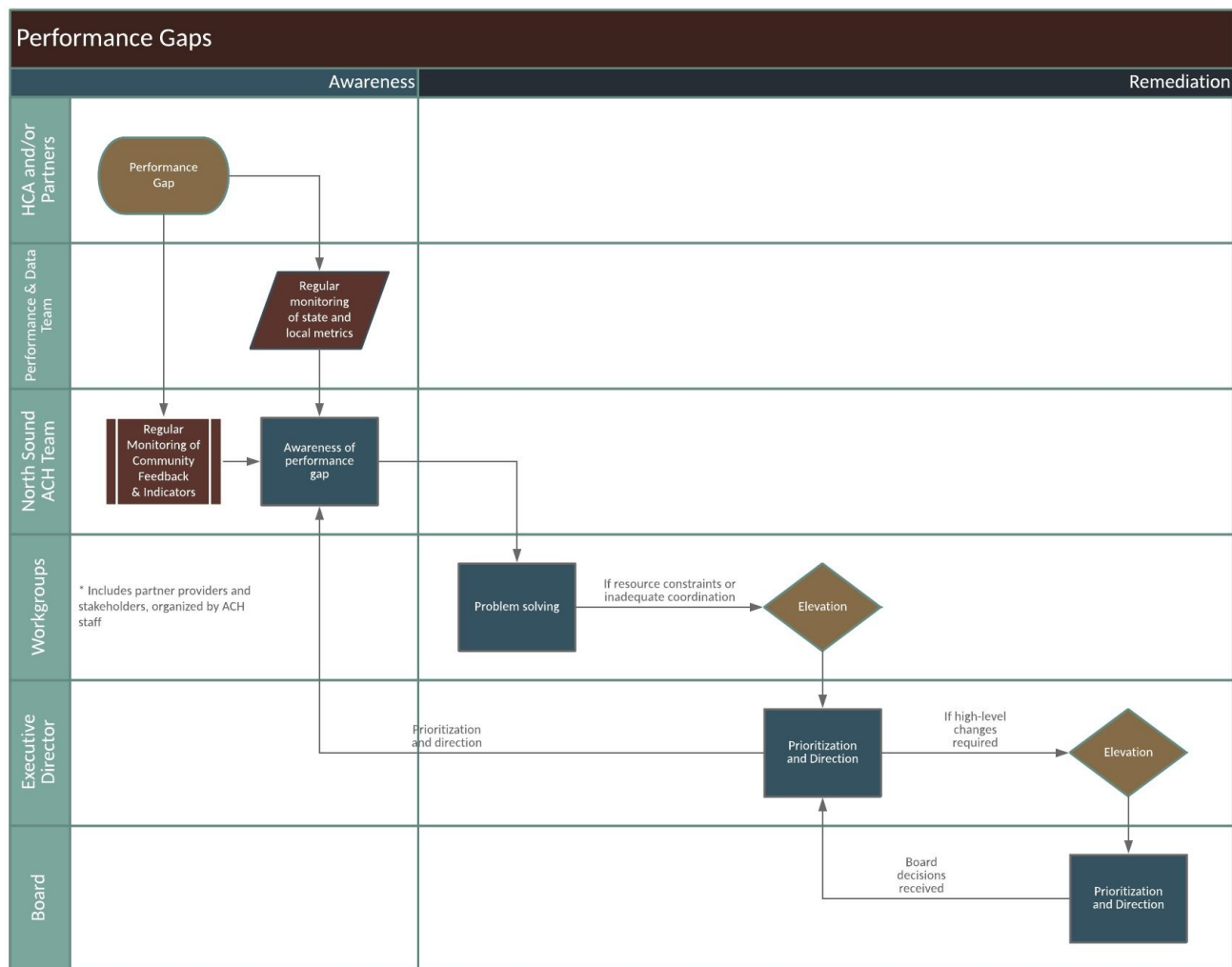
- One-on-one technical assistance from the North Sound ACH Team
- Technical assistance from contracted TA providers
- Online resources such as webinars, on-demand trainings
- Coaches or on-site assessment and PDSA assistants

It is critical that partners see the identification of delays in a positive light and not simply as a threat to their scores and potential earnings. When implementation is delayed or encounters a barrier, partnering providers will first attempt rapid cycle improvement processes such as Plan-Do-Study-Act (PDSA) cycles to solve these challenges and report outcomes to North Sound ACH Project Managers. If their internal method does not lead to improvement, North Sound ACH Project Managers will collaborate with partners, the ACH Data and Learning team, the Program Council and technical assistance consultants to address implementation delays.

Technical assistance, trainings and other resources will be supplied as needed to partner organizations and individual providers for additional supports after review of data and a deliberative process between the North Sound ACH team, the Data and Learning team, and implementation partners, along with feedback from the Program Council.

As illustrated in Figure 5 below, the North Sound ACH will monitor two primary signal paths for indications of performance gaps: (a) regular monitoring of state and local metrics by the data and learning team and (b) regular monitoring of community feedback and indicators by the project managers in their capacity as activity leads. In the latter case, a primary function of the activity teams will be to reveal performance gaps. Independently and in cooperation with the team, activity leads will routinely probe for indicators of lagging achievement by employing site visits, having meetings with providers, and conducting periodic surveys.

Figure 5: North Sound ACH process for addressing performance gaps



For CCA partners, support will be provided to ensure that partners are able to meet project milestones. The ACH will provide access to trainings, technical assistance, and mechanisms for partners to identify and escalate support needs.

The Community HUB team will rely on data entered in the CCS platform to identify and mitigate barriers to partners' achievement of project milestones, and to monitor partner data integrity and completion. The HUB Manager will elevate quality concerns to CCAs and the HUB Director, driving discussion about additional training and support needs. The HUB committees will discuss quality concerns and recommend additional support or training needs critical to achieving HUB project milestones.

ALIGNMENT WITH OTHER PROGRAMS

Explain how the ACH ensures partnering providers avoid duplication while promoting synergy with existing state resources from DY 2, Q3 through DY 3, Q4. Responses must cover the following:

Project 2A

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?*

Project 3A

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports?*

For ACHs implementing Project 2B

- *How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?*
- *What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?*
- *How is the ACH's approach aligned with MCO care coordination contract requirements?*

For ACHs implementing Project 2C

1. *How does the project align with or enhance related initiatives such as Health Homes or other care/case management services, including those provided through the Department of Corrections?*
2. *What additional programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve transitional care services?*

For ACHs implementing Project 2D

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to promote appropriate use of emergency care services and person-centered care? (e.g., the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives.)*

For ACHs implementing Project 3B

- *How do the ACH's partnering providers align with and avoid duplication of Maternal Support Services? How will the project strengthen or expand current implementation of Home Visiting Models?*
- *What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve access to high quality reproductive and maternal/child health care?*

For ACHs implementing Project 3C

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve access to oral health services?*

For ACHs implementing Project 3D

- *What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?*

ACH RESPONSE

North Sound ACH Alignment with Other Programs: Overview

The North Sound ACH will ensure partnering providers avoid duplication while promoting synergy with existing state resources from DY 2, Q3 through DY 3, Q4, in several ways:

- The ACH will utilize the experience of partners with content expertise in partnership or navigation of each ACH initiative area in order to collaboratively develop a resource library of agencies, programs, and initiatives serving the populations of focus for each strategy (inclusive of referral requirements and processes).
- The ACH will work with each initiative and/or strategy Lead agency (referenced in the attached Work Plan) to determine the most appropriate and sustainable communication mechanisms for disseminating information about existing state resources out to partners.
- The ACH will expand and scale the Community HUB model of dedicating ACH staff to be a primary contact point for incoming information on existing/new services, and maintenance of the external communication process to inform relevant partners.
- All ACH partnering providers have signed an attestation to their understanding that ACH funds cannot be used for any other programs that use Medicaid dollars.
- The ACH will promote partner alignment with existing resources (and between partners) by providing or facilitating trainings and technical assistance related to community resources and how patients/clients can access them.

For purposes of this Implementation Plan, the questions and responses below will be laid out by project area. However, the North Sound ACH has folded strategies from the eight toolkit project areas into the following four initiatives: Care Coordination, Care Transformation, Care Integration, and Capacity Building. Please see Pages 4-6 and Attachment A for a full description of these initiatives and how regional Medicaid Transformation strategies fit into them.

Project 2A - Bidirectional Integration of Physical and Behavioral Health (required)

What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other bi-directional integration efforts in the state?

In order to align with (but not duplicate) statewide efforts to implement bi-directional integration of physical and behavioral health, the ACH has worked closely with the North Sound Behavioral Health Organization (BHO), leadership in local behavioral health agencies, federally qualified health centers, and primary care delivery systems to identify existing pilot activities and avoid duplication of efforts.

Because of the importance in identifying successful pilot projects in sharing best practices and lessons learned in developing integration efforts that will succeed in the regional context, the North Sound ACH has sought to leverage and highlight the work of these pilots in planning implementation activities. This has involved ongoing meetings with representatives from specific initiatives as well as the participation of practice transformation coaches and representatives from bi-directional integration efforts in ACH implementation planning and partner engagement events.

These local pilot activities and bi-directional integration efforts include:

- Mental Health Integration Pilot
- Pediatrics Transforming Clinical Practice Initiative (p-TCPI)

- Practice Transformation Support Hub
- PeaceHealth Pediatrics and Telepsychiatry Pilot
- Lake Whatcom Center's co-located ARNP

Project 3A - Addressing the Opioid Crisis (required)

What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports?

The North Sound ACH has aligned with the Governor's Opioid Response Plan and is coordinating with its local implementation. The North Sound BHO has been supporting the plan through development of the Opioid Regional Plan, around which the ACH and its partners have focused the development of project strategies.

In addition, the following programs or services have been identified to facilitate alignment with but not duplicate:

- "Hub and Spoke" Networks of medication-assisted treatment providers, supported by the Division of Behavioral Health and Recovery (DBHR) in the State Targeted Response to the Opioid Crisis
- Regional Community Prevention Wellness Initiative Coalitions
- Local county and tribal efforts to implement Department of Health (DOH) and DBHR public health campaigns that educate the public about the risks of opioid use and promoting safe storage options
- Naloxone distribution and care coordination efforts in collaboration with regional syringe services providers, DBHR, DOH and UW's Center for Opioid Safety Education

North Sound ACH program staff and key partners will participate in ongoing state meetings to stay abreast of progress and new initiatives and avoid duplication.

Project 2B - Community-Based Care Coordination

How does the ACH align referral mechanisms and provider engagement strategies with the Health Homes and First Steps Maternity Support Services program?

North Sound ACH has worked to align community-based care coordination referral mechanisms since the selection of the Community HUB as a transformation strategy.

In DY2, Q1-Q2 ACH staff co-led meetings with Medicaid MCOs and Health Home Lead Agencies to discuss alignment opportunities and barriers. The conversations focused on the exchange of information and flow of client data, as well as the identification, placement, and flow of clients between Health Homes and the HUB model. These meetings resulted in agreement on a bi-directional referral flow between Health Home Leads and the North Sound Community HUB. (See Figure 6 on following page.)

The flowchart illustrates the process for determining HH eligibility and the subsequent social service pathway. It is divided into two main sections by a dashed line.

Top Section: Initial Eligibility and Coordination

- HUB Determine HH Eligibility** (Orange box) leads to:
 - Identify those in the HUB became HH eligible
 - Hub shares pathway Engagement files with lead
- Create FTP site with CCS** (White box) leads to **MCO/LEAD** (Green box).
- MCO/LEAD** leads to:
 - Create Eligibility files to share with HUB
- MCO/LEAD** leads to **HUB to notify care coordination agency to open social service referral for health homes** (Blue box).
- HUB notifies the Lead and CCA that the patient is now HH eligible (recommend within 3 business days)** (White box) leads to:
 - CCA will begin client termination process and transition to health homes. Pathway program termination results in the closure of social service pathway** (Dark Blue box).
 - Lead will coordinate warm hand-off between CCA and CCO** (White box).
- Lead will coordinate warm hand-off between CCA and CCO** leads to **Enroll in HH (ASAP)** (White box).
- Enroll in HH (ASAP)** leads to **Data exchange back to Lead from HUB** (Red box).
- Enroll in HH (ASAP)** leads to a decision diamond: **Op in?**
 - Yes** leads to **Stay with HUB if appropriate/ pathway remains open** (White box).
 - No** leads to **Opt out form completed by CCO communicated to Lead sent HCA** (White box).

Bottom Section: Detailed Eligibility and Engagement

- MD, Church, MCO, ED** (Yellow boxes) lead to **Target Population Referral** (Green arrow).
- Target Population Referral** leads to **HUB Determine HH Eligibility** (Orange box).
- HUB Determine HH Eligibility** leads to:
 - HUB will close the loop with referrals** (Red text).
 - HUB will contact Leads via email as Referral comes in** (Red text).
- HUB Determine HH Eligibility** leads to **MCO/LEAD** (Green box).
- MCO/LEAD** leads to:
 - Respond back to the HUB within One business day to include Which bucket the patient is in** (Green text).
 - HUB will start intake assessment for bucket B** (White box).
- MCO/LEAD** leads to three buckets:
 - Bucket A: Stay with HH** (Orange box):
 - HH engaged
 - UTC 90 < days
 - Bucket B: Care Coordination Services go to HUB** (Orange box):
 - Formal Opt out HH
 - No engagement and PRISM < 1.0
 - UTC > 90 days
 - Bucket C: If the person is not engaged, the lead will assign to a CCO and work with the HUB on locating and connecting with the person** (Orange box).
- What to do if patient become eligible for HH during the process?** (White box):
 - System check HH eligibility monthly
 - We want HH referral to be a result of closing pathway
 - HUB will referral back to the leads
- MCO Send email to HUB including** (White box):
 - Opt out
 - No engagement and <1.0
 - UTC>90 days
 - Critical safety information
 - Lead will share OPT out form with HCA permission/compliance

- Internal staff: A referral triage policy will be developed and maintained by HUB Intake and Referral staff. This individual will be trained in how to avoid intaking clients who are already being served elsewhere.
- HUB Care Coordinators will receive training around intake policy and procedure, which includes searching for duplication in the CCS software. Intake checklists will require the care coordinator to determine if other organizations are providing services to the client. If duplication is detected, the care coordinator will facilitate connecting the individual back to the agency providing services.
- External partners: Key referral and service providers will be provided a login to access the CCS interface where they can see if an individual is already connected to the HUB. This real-time ability for partners to see if/where individuals are receiving care is critical to avoiding duplication.
- The North Sound ACH and its partners in maternal and child health will work together to find alignment in referral mechanisms and engagement strategies with partnering providers and other state programs (such as First Steps' Maternity Support Services), using a similar approach to that used to find alignment with Health Homes while avoiding duplication with Health Homes (see Figure 6).
- In addition, ACH partnering providers focused on serving pregnant or parenting women and infants in the North Sound region are closely aligned with the state's First Steps program, which includes maternity support services. Nearly all First Steps providers in the North Sound region are also North Sound ACH partnering providers, and these partners have attested to their understanding that ACH funds cannot be used for any other programs using Medicaid dollars. Referral to Maternity Support Services providers

who provide patient/client education around pregnancy and parenting, screening and counseling for pregnancy risk factors, and referral to community resources will be integrated into implementation activities between DY 2, Q3 and DY 3, Q4.

What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve care coordination?

The ACH is committed to designing care coordination strategies that are aligned and non-duplicative to other state efforts. Some initial work includes:

- Development of a bi-directional process for referrals between Health Homes and the HUB in conjunction with MCO representatives, the HCA and Health Homes Lead organizations, facilitated by the LEAN Team at Molina.
- Recruitment to HUB Advisory Committee of potential referral sources and provider partners to discuss care coordination program inventory and alignment opportunities.
- Meetings with HCA to discuss state and regional HCA resources for care coordination, including referral processes, participation requirements, and local contact information.
- Cross-ACH discussions with the other ACH HUBs, HCA, and the Department of Health regarding statewide efforts and resources for integration of CHWs into care coordination initiatives.

How is the ACH's approach aligned with MCO care coordination contract requirements?

The ACH is committed to involving MCOs as partners in care coordination contract requirements to ensure the initiatives are aligned with and ultimately sustainable by payer funding. Some initial work to ensure this alignment includes:

- Including MCO representatives in selection of the Community HUB population of focus.
- Working with representatives from all MCOs to develop the HUB - Health Homes Bi-Directional Referral Process, a collaborative that included Health Homes leads from the region.
- Discussion with the Health Care Authority about the Bi-Directional Referral process to ensure that consistency with MCO contract requirements.
- Submission of signed Business Associate Agreements to discuss HUB contracting with MCOs.
- Developing outcome-based reimbursement rates with MCOs.
- Working with MCOs to identify their key VBP and HEDIS measures and aligning the Community HUB's contracting parameters around any Pathways that could affect those measures.
- Working with MCOs to determine the evaluation vendor/service that could showcase the cost savings associated with care coordination strategies.

Project 2C - Transitional Care

How does the project align with or enhance related initiatives such as Health Homes or other care/case management services, including those provided through the Department of Corrections?

North Sound ACH is adapting strategies from the eight toolkit project areas into four comprehensive initiatives (Please see Attachment A for details on the initiatives and strategies). During this process, ACH staff determined that all strategies related to care coordination need to be aligned with the Community HUB.

North Sound ACH participated in work to align all care coordination strategies with the Health Homes model. These meetings identified paperwork and timelines specific to transitioning clients between the care models via a

warm handoff process. Regarding Health Homes, there are a number of clients eligible for Health Homes who do not enroll in the program due to any of the following:

- Inability to engage the individual within the 90-day window permitted within the model,
- Client opt out
- PRISM score changes that move them out of the model's eligibility threshold.

Discussion around the Community HUB and Health Homes centered on how the HUB can fill this service gap in the Health Homes model.

In early development of the North Sound Community HUB, partnering providers and the MCOs saw an opportunity to align development of the Community HUB with transitional care models and interventions already in place. The HUB Advisory Committee will develop a plan to broadly engage referral and care coordination providers, including those engaged at transition points of care. Planning will include EMS and first responder organizations and coalitions across the region to align referral mechanisms and engagement strategies with key transitional care partner organizations such as Northwest Regional Council, Compass Health, and the North Sound BHO.

Initial actions include:

- Invite the North Sound BHO to serve on the HUB Advisory Committee for discussion of referral alignment and contribution to the HUB's Community and Partner Engagement Plan.
- Invite EMS, DOJ, or crisis center representatives to attend HUB Advisory Committees and HUB Convenings for discussion of referral alignment and contribution to the HUB's Community and Partner Engagement Plan.
- Invite county health departments that currently have cross-sectoral initiatives. including DOJ representatives. Facilitate conversations that leverage their best practices and lessons learned in navigating DOJ initiative, workflows, and resources currently underway. Use this best practice as a blueprint for scaling to a regional level of collaboration.
- Leverage the strategies and collaborations in the diversion and Community HUB project areas. Both strategies engage first responder partners such as EMS, and criminal justice partners such as police, and fire departments.

What additional programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve transitional care services?

Throughout DY1, the North Sound ACH convened regional leaders from care transition initiatives for the purpose of shared learning and locating program alignment. There were high levels of engagement from clinical inpatient partners, community-based organizations, tribal nations, MCOs and county governments. Workgroup Leads include representatives from a large regional health system (Providence Medical Center) and a Managed Care Organization (Amerigroup). The focus of the Care Transitions Work Group was to engage a broad set of stakeholders in identifying the components of successful care transitions models that could be scaled, while avoiding duplication. This level of leadership strengthened the number of partners who responded to our Call for Partners, interested in jail and inpatient transition efforts.

Project 2D - Diversion Interventions

What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to promote appropriate use of emergency care services and person-centered care? (e.g., the Washington State Hospital Association's "ER is for Emergencies" and "Seven Best Practices" initiatives.)

The North Sound ACH has reviewed several programs and services to model its care coordination initiative around, including the Seven Best Practices (most commonly used by Emergency Departments). Community paramedics identify patients with frequent 911 calls leading to EMT dispatch, provide patient education to frequent callers that results in more appropriate use of the emergency department, and collaborate with primary care and other community providers to develop shared care plans for such frequent callers.

Community paramedics are often an alternative to emergency departments, by working in partnership with social service agencies to expedite coordinated care and referrals. To facilitate non-duplicative alignment with community paramedicine programs, representatives from the region's fire and EMS departments have provided input on operational elements of the other care coordination strategies that could potentially lend to or mitigate service duplication. For example, Fire and EMS could work with the HUB Advisory Committee in development of the HUB's referral policy/procedure to ensure that it addresses and helps mitigate overlap with the community paramedicine project area.

Another strategy within our Care Coordination initiative is what we are calling cross-sector collaboration for complex cases. This type of collaboration has two examples in the North Sound region -- CHART (Chronic-Utilizer Alternative Response Team) in Everett and GRACE (Ground-level Response and Coordination Engagement) in Whatcom County -- that promote shared learning of best practices and better coordination of care and services for patients who often use the emergency department for non-emergent conditions. These collaborations will develop shared care plans that are complementary to the Community HUB and Health Homes. The intention of the Community HUB is to enhance connectivity, share information, and foster opportunities for agencies to better see the range of organizations that have been in touch with a person or family. The Community HUB will be able to refer to community paramedic programs, cross-sector collaboratives for complex cases (such as GRACE or CHART), or other community organizations providing care coordination services.

The current diversion initiatives involve a local hub-and-spoke network structure for cross-system identification and care coordination of complex cases, which enhances and links networks to align work in non-duplicative ways. The intent is to support local care coordination structures by pooling resources for shared functions and utilities, particularly involving tools for information sharing and methods for engaging complex, high-cost individuals.

Project 3B - Reproductive and Maternal/Child Health

How do the ACH's partnering providers align with and avoid duplication of Maternal Support Services?

ACH partnering providers focused on serving pregnant or parenting women and infants in the North Sound region are closely aligned with the state's First Steps program, including maternity support Services. Nearly all First Steps providers in the North Sound region are also North Sound ACH partnering providers, and these partners have attested to their understanding that ACH funds cannot be used for any other programs using Medicaid dollars.

North Sound Medicaid Transformation Project strategies in project area 3B will focus on two key pieces of reproductive, maternal, and child health:

- Reproductive health: prevention of unintended pregnancy through increasing access to LARC and the One Key Question pregnancy intention screening
- Maternal and child health: implementing the HealthySteps program in pediatric practices serving Medicaid patients.

The goal of the HealthySteps program is to increase the capacity of physical health care practices to support the health and development of children and their families. HealthySteps adds a child development professional (HealthySteps Specialist) to the practice as an integral part of the physical health care team. The model supports implementation of Bright Futures recommendations (the evidence-based model listed in the MTP Toolkit to promote well-child visits), supports early childhood behavioral health integration into pediatric physical health care. It includes opportunities to ensure identification of parental behavioral health concerns and supports parental connections to family planning for healthy pregnancy spacing. Strategies in this project area do not duplicate the prenatal and postpartum support for mothers and infants. Therefore, alignment with maternal support services and other First Steps programs will be critical and integrated into implementation activities between DY 2, Q3 and DY 3, Q4.

How will the project strengthen or expand current implementation of Home Visiting Models?

North Sound ACH will not be implementing additional home visiting strategies, although partnering providers currently have programs that include home visiting that will be linked through the Community HUB and its CCAs. North Sound ACH will focus on prevention of unintended pregnancy (through increasing access to LARC and the One Key Question pregnancy intention screening) and implementing the HealthySteps program in pediatric practices (the HealthySteps program operationalizes the Bright Futures model).

ACH staff and partners will be in communication with providers of home visiting programs in operation in the North Sound region (such as Nurse Family Partnership, Early Head Start, and Family Spirit in tribal communities) to ensure alignment and coordination. Many providers of these home visiting programs are already North Sound ACH partnering providers and will benefit from capacity-building efforts during the Medicaid Transformation Project. Alignment and coordination will be particularly critical when target populations align with North Sound ACH strategies, such as the North Sound Community HUB, and in embedding HealthySteps specialists in pediatric practices. The HUB will make referrals as appropriate to home visiting programs as part of its work with the population of focus: pregnant women who are experiencing BH and substance use disorders.

What other programs or services has the ACH identified to facilitate alignment with, but not duplicate, other state efforts to improve access to high quality reproductive and maternal/child health care?

In addition to the First Steps program (which includes maternity support services, infant case management, and childbirth education) and home visiting programs (like Nurse Family Partnership, Early Head Start, and Family Spirit in tribal communities), the North Sound ACH has identified other state reproductive and maternal/child health programs to align with:

- Pediatric Transforming Clinical Practice Initiative (p-TCPI), which is currently active in the North Sound region, supports practice transformation for pediatric providers.
- Help Me Grow Washington, which offers developmental screening for all kids under age five, referral to parenting classes, medical care, food banks, further evaluation, and early intervention services.

The North Sound ACH will also leverage the work of Upstream USA, a nationwide nonprofit quality improvement organization that provides training and technical support to eliminate barriers at health centers that prevent a

woman from obtaining the birth control method of her choice, improving outcomes for parents, children, and society. Upstream USA will provide trainings for clinical and support staff at physical health care providers. Content will include LARC counseling and insertion, implementing the One Key Question pregnancy intention screening model, and general clinical practice transformation to reduce unintended pregnancy and support improved health outcomes for women of reproductive age and children. Upstream USA has recently begun operations in Washington state (2018 is year one of their five-year project) and will be working in multiple ACH regions across the state.

Project 3C - Access to Oral Health Services

What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve access to oral health services?

In order to align ACH activities with Medicaid and other state-level efforts to improve access to oral health, the North Sound ACH has worked closely with the Arcora Foundation to engage local leadership and partners in oral health promotion and access to care. In a complementary effort that will expand our oral health capabilities and funding, the North Sound ACH is also partnering with Arcora Foundation to launch a Local Impact Network (LIN), which will seek to build on ACH initiatives, existing regional capacity, state-level ongoing activities, and additional oral health strategic priorities.

The North Sound ACH will coordinate with several state-wide initiatives, while avoiding duplication, including:

- ABCD (Access to Baby and Child Dentistry) activities undertaken by the four local ABCD grantees.
- Significant FQHC capital expansion funded by the 2018 legislature to build facilities for child and adult dental care in Snohomish, Skagit, Island, and Whatcom counties.
- Dental workforce capacity expansion through dental health aide therapists (DHAT), a new type of mid-level provider, at the Swinomish Health Center with curriculum provided through Skagit Valley College.
- Managed care in the dental sphere as authorized by the legislature for 2019. Among other impacts, this will spread value-based payment in the dental sector.
- Integration of medical primary care and oral health services.

Project 3D - Chronic Disease Prevention and Control

What are the programs or services the ACH has identified to facilitate alignment with, but not duplicate, other state efforts to improve chronic disease management and control?

In order to align ACH activities with Medicaid and other state-level efforts to improve chronic disease management and control, the North Sound ACH has worked closely with partnering providers who led implementation planning efforts to identify state programs or services serving Medicaid patients with chronic conditions (specifically, asthma, diabetes, and/or heart disease), including the following:

- ACH strategies will build on, but not duplicate, regional chronic disease prevention and management programs that are evidence-based, state-funded by the Washington State Diabetes Prevention and Control program, and eligible for Medicaid reimbursement, including:
 - Chronic Disease Prevention and Management Programs (CDSMP)
 - National Diabetes Prevention Programs (NDPP)

- In developing the North Sound Community HUB, the North Sound ACH is being very deliberate to align with but not duplicate Health Homes services. This alignment will inform the implementation of chronic disease strategies. Please see the response above for Project 2B, beginning on page 29.
- Transforming Clinical Practice Initiative (TCPI)
- Healthier Washington Practice Transformation Support Hub and Resource Portal, which provides access to information and practice coaching on implementing evidence-based approaches to chronic disease prevention and management.
- Living Well, an online hub/portal with resources for people experiencing chronic conditions, hosted by the DOH.
- Washington State Asthma Plan.
- Asthma Home Visiting Programs (state funded through the Department of Commerce Energy Matchmakers fund for Weatherization plus Health).
- Wisdom Warriors, an approach using the Stanford Chronic Disease Self-Management Programs that has been successfully refined to be culturally appropriate and specific to tribal health.

REGIONAL READINESS FOR TRANSITION TO VALUE-BASED CARE

Explain how the region is advancing Value-based Care objectives.

Responses must cover the following:

- *What actionable steps are partnering providers taking from DY 2, Q3 through DY 3, Q4 to move along the VBP continuum? Provide three examples.*
- *What is the role of the region's provider/practice champions as it relates to providing guidance to regional partners in support of value-based care goals?*

ACH RESPONSE

North Sound ACH advancement of value-based care objectives

Value-based payment (VBP) arrangements between the North Sound ACH's partnering providers and health care payers such as MCOs are sensitive and often proprietary contracts, and the North Sound ACH will not be playing a direct role in facilitating or guiding the development of these contracts. However, partnering providers will receive better reimbursements and overall financial benefit in VBP arrangements through improved performance on clinical quality measures, driven by better patient outcomes, increased efficiency, and improved use of health information technology. The North Sound ACH will support partnering providers' efforts in each of these areas. Additionally, the North Sound ACH plans to provide technical assistance aimed at improving their capacity to negotiate strong VBP contracts.

ACH Collaboration

The nine ACHs have been working with HCA to clearly define the ACH role in relation to VBP. Guided by these discussions, the ACHs will engage in a range of activities designed to improve partners' VBP capacity;

- Assess provider VBP readiness
- Articulate and reinforce opportunities of advanced VBP contracting
- Link providers to VBP resources, especially those providers who are less familiar with VBP.
- Promote provider participation in surveys and assess results
- Allocate DSRIP project incentives in ways that prepare providers to participate in VBP contract arrangements

What actionable steps are partnering providers taking from DY 2, Q3 through DY 3, Q4 to move along the VBP continuum? Provide three examples.

Actionable steps partnering providers are taking to move along the VBP continuum include:

- Over the course of 2019, Behavioral Health Agencies (BHAs) in the North Sound region will begin directly contracting with Managed Care Organizations to provide behavioral health services paid for by Medicaid. These arrangements could involve value-based payment contracts and the North Sound ACH will be supporting BHAs in accessing value-based contracts through technical assistance, coaching, and other resources.
- Partnering providers that are traditional Medicaid providers will receive training and technical assistance in usage of health information technology and health information exchange (HIT/HIE) that will increase their ability to implement population health management methodologies, report clinical quality measures, and engage in more advanced alternative payment models.

- Relationships between traditional and non-traditional Medicaid providers are being facilitated through the North Sound ACH's implementation planning process. Stronger partnerships and shared care planning, facilitated by HIE, across clinical and non-clinical service settings will be critical for advancing VBP readiness.

What is the role of the region's provider/practice champions as it relates to providing guidance to regional partners in support of value-based care goals?

The North Sound region has a provider champion in Francie Chalmers, MD, a Skagit County pediatrician who has taken a leadership role in supporting value-based goals. Through her work, she has led taken part in other discussions across project areas and has supported other providers in her practice to take part in trainings, our two-day partner retreat in August, and other meetings.

Through the partner-assessment process and statewide VBP survey, the North Sound ACH is hoping to identify additional regional leaders and high performers as potential provider champions in advanced alternative payment arrangements. Once these champions are identified, the ACH will provide channels for them to lead others (e.g. website, email updates, in-person trainings for providers).

The ACH will select and support these champions who are able to share and disseminate best practices and success strategies based on their experience in negotiating successful VBP contracts. As the region moves toward improvement in VBP contracts and performance, partnering providers will have the opportunity to learn from these champions through site visits, office hours, and webinars.

REGIONAL READINESS FOR HEALTH INFORMATION TECHNOLOGY (HIT) / HEALTH INFORMATION EXCHANGE (HIE)

Explain how the region is advancing HIT/HIE objectives.

Responses must cover the following:

- *What actionable steps are the ACH taking to facilitate information exchange between providers at points of care? Provide three examples.*
- *How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems?*

ACH RESPONSE

North Sound ACH advancement of regional HIT/HIE objectives

The North Sound ACH is taking steps to advance HIT/HIE objectives through training, technical assistance, and capacity-building resources that help providers obtain, implement, and optimize HIT and HIE products. These include supporting BH providers that are transitioning to electronic billing, assisting emergency departments that are connecting to EDIE or PreManage, and seeking to optimize use of current EHRs for population health management.

What actionable steps are the ACH taking to facilitate information exchange between providers at points of care? Provide three examples.

The ACH is taking the following steps to facilitate information exchange between providers:

- Supporting BHAs in implementing PreManage for shared care management through technical assistance and the exchange of best practices for applying HIE to care planning.
- Launching the Community HUB so partners providing care to clients enrolled with the Hub can access patient care and pathway completion updates through the CCS platform interface and direct messaging protocols.
- Supporting providers in direct electronic referral processes between primary care settings and chronic disease self-management providers and other community settings to confirm complete referrals and patient status.

How is the ACH leveraging Transformation incentives, resources, and activities to support statewide information exchange systems?

The North Sound ACH is working closely with other ACHs across the state to identify areas of opportunity for collaboration on leveraging Transformation incentives, resources, and activities to support statewide information exchange systems. The following are some examples of this collaboration:

- ACHs that are working on Pathways implementation meet monthly to discuss coordination. This has resulted in a contract with CCS that builds upon work done by each ACH, rather than separate, uncoordinated contract arrangements.
- To date, three ACHs have entered into contracts with CSI Solutions to develop a reporting platform for partnering providers and each are building upon the work already done, so that partners working across ACH boundaries will have a common set of language and reporting items.

- ACHs have met with Collective Medical Technologies independently and together to assess existing use and opportunities for statewide expansion of the EDIE and PreManage platforms.
- Four ACHs are contracting with King County Public Health, which has access to the all-payer all-claims database, to develop common reporting and analysis.

The ACHs are in very early stages of discussions to leverage statewide information exchange systems. Because we have each been primarily focused on independent project plans, the semi-annual report, and implementation plans, we have not been able to optimize time to work on this jointly but there are explicit commitments from multiple ACHs to do so.

TECHNICAL ASSISTANCE RESOURCES AND SUPPORT

Describe the technical assistance resources and support the ACH requires from HCA and other state agencies to successfully implement selected projects.

Response should cover the following:

- *What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?*
- *What technical assistance or resources does the ACH require from HCA and other state agencies?*
- *What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?*

ACH RESPONSE

In responding to the semi-annual report, the nine ACHs collaborated to develop a list of support that the ACHs require from HCA and other state agencies to implement our projects successfully. The support was divided into two sections: technical assistance and administrative support.

Technical assistance needs include:

- HCA and the ACHs collectively identify opportunities for collaboration related to HIT/HIE
- Strong partnerships with Washington State Hospital Association
- HCA guidance on the ACHs' role in moving toward whole person care and value-based payment
- Stronger collaboration with HCA and MCOs, to prevent ACHs from treading unproductively into the HCA-MCO contractor realm
- Fuller understanding of the ACH role in supporting VBP contracts between HCA, MCOs, and provider organizations
- ACH and HCA continued collaboration to find interoperability solutions to shared care planning, care management for high-risk populations, clinical/community linkages, and population health management
- The state's ongoing role in the Practice Transformation Support Hub, the P-TCPI Practice Transformation Network, and its vision for continuity after January 2019
- Clear timelines and transparency about the extent of continued support planned—and needed—for practice transformation resources and initiatives
- Systems for population health management support, including:
 - Data governance
 - Interoperability
 - HIE
 - Disease registries
 - Telehealth
 - PreManage/EDIE
 - Centralized registries
- Training and technical assistance for key workforce positions within required projects (e.g., CHWs, peer support specialists, care coordinators, behavioral health specialists)
- Training and technical assistance for common training needs: MAT, PMP, 6 Building Blocks, Transitional Care models, Trauma Informed Practices, Cultural Sensitivity

- Tailored guidance for rural health providers (both larger providers and smaller rural health clinics/critical access hospitals) in relation to VBP and rural multi-payer models
- Resources tailored to behavioral health providers that need to build capacity for quality improvement and measurement as they look ahead to quality-based payment
- Best practices and strategies specific to billing/coding for health care providers, aligning payments with the intent behind bi-directional integration (i.e., DOH's Practice Transformation Hub is coordinating with the UW AIMS Center to provide guidance on collaborative care codes)

In addition, the ACHs identified **administrative support** that the HCA and state partners could provide that would contribute to successful project implementation and sustainability.

- Approval of behavioral health integration codes would significantly impact long-term sustainability of integrated care, alleviate initial financial costs to develop an integrated care program, and allow organizations more flexibility to adapt core principles of collaborative care to their specific practice settings
- Streamline the Washington State credentialing process for medical and behavioral health professionals, including telemedicine, to lessen the costs of hiring
- Regular communication and access to results from state-level health system capacity surveys such as the Value-based Payment survey, the Washington State Health Workforce Sentinel Network, and the Medicaid EHR Incentive Program
- Engagement of ACH staff and key partners in design and dissemination of surveys, with the goal of limiting redundancy and increasing response rates
- Ensure that information held in data repositories (All-Payers Claims Database and Clinical Data Repository) is accurate, accessible, timely, and useful to transformation
- Support Dental Health Aide Therapists and other dental professions that expand capacity and improve access to oral health care for people enrolled in Medicaid
- Increase capacity and access to practice transformation coaches, clinical subject matter expertise, change management expertise, workforce training, and collaborative tools needed to work across ACH regions
- Improve coordination with the Department of Health to ensure coordinated opioid prevention efforts
- Bring more alignment to measures and incentives across payers; reducing variability in how providers are rewarded for performance would allow providers to focus on the work of providing better care
- Advocate for increased Medicaid rates in Washington State -- providing adequate financial incentives is key to supporting the sustainability of Medicaid Transformation Projects
- Taking leadership role on regulations that are a barrier to MTP goals, specifically behavioral health information exchange (42 CFR, Part 2); these laws prevent progress toward the goals of health care reform and health information exchange

What technical assistance or resources have the ACH identified to be helpful? How has the ACH secured technical assistance or resources?

The response above identifies specific technical assistance and resources that the ACH has identified to be helpful from HCA and state partners. We have worked in collaboration with other ACHs, HCA, the Washington State

Department of Social and Health Services, the Washington State Department of Health, and the University of Washington AIMS Center to seek resources and technical assistance. We have sought to optimize public resources by not entering into contracts that require DSRIP funds but plan to pay for some services using DSRIP earnings. For example, we plan to contract with the University of Washington's AIMS Center to provide training, technical assistance, and development resources to partnering providers who are implementing bi-directional integration models. It is unclear, however, when services do and don't require a contract.

In general, technical assistance has been secured via contracts with external vendors. Specifically, technical assistance around funds flow, fund allocation modeling, governance and evaluation have been critical to our progress to date. At times each ACH has secured separate TA, but in the past year there is more cross-ACH discussion around contracting with vendors and for TA. Five ACHs currently contract with the Center for Evidence Based Policy; four ACHs contract with CORE; and four ACHs are exploring contracts with CCHE (evaluation and team facilitation), the Haas Institute (equity) and others to provide needed resources.

What project(s)/area(s) of implementation would the ACH be interested in lessons learned or implementation experience from other ACHs?

Because the North Sound ACH has partners and community members who cross ACH boundaries, we feel it is imperative to coordinate with the ACHs that border our region and to adopt similar approaches wherever possible.

The North Sound ACH is in constant collaboration with other ACHs, learning from their experiences in their SIM-funded Early Win projects (e.g., Better Health Together and its work in the Pathways pilot) and their negotiations with partners to define partner agreements on implementation strategies. We continue to seek experience and technical assistance from other ACHs related to:

- Opioid reduction strategies
- Collaborative approaches such as North Central's Whole Person Care Collaborative and Olympic Community of Health's Natural Communities of Care
- Approaches implementing the Pathways infrastructure and platform
- Approaches to the design of our partner reporting portal with CSI
- Approaches to optimizing use of preManage and EDIE

Attachment A: North Sound ACH Initiative Descriptions

North Sound ACH Initiatives and Strategy Portfolio

Initiative	Initiative Description	Initiative Project Areas	Initiative Strategy Objectives
Care Coordination	<p>The North Sound ACH will use or enhance existing services in the community to promote care coordination across the continuum of health, ensuring those with complex health needs are connected to the appropriate interventions and services needed to improve and manage their health. In addition, this initiative will develop linkages between care coordinators by utilizing a common platform that improves communication, standardizes use of evidence-based care coordination practices, and promotes accountable outcome monitoring for beneficiaries being served.</p> <p>Strategies within the initiative will be designed and implemented to meet the needs of the region's identified high-risk, high-needs target populations.</p> <p>Project Areas include:</p> <ul style="list-style-type: none"> • Community-Based Care Coordination (2B) • Transitional Care (2C) • Diversion Interventions (2D) 	2B, 2C, 2D	<ul style="list-style-type: none"> • Promote community-based care coordination by launching a Community HUB that will connect care coordinators who reach Medicaid enrollees. The Pathways model provides a starting point from which to pilot, scale and sustain community-based care coordination. (2B) • Improve community transition efforts by enhancing communication between emergency departments, hospitals discharge, behavioral health settings, law enforcement, courts, and jails. As well as using the North Sound Community HUB as a communication and coordination tool, strategies in this initiative will identify transitional gaps, initiate referral to community-based partners, and foster continued collaboration around populations experiencing high-needs. (2C) • Divert community members from avoidable emergency room visits by supporting cross-partner coalitions who are developing and implementing coordinated systems that promote care coordination for people with complex needs that intersect with health care, social service, criminal justice, and emergency systems; and promoting access

			to appropriate non-emergency services through community-based programs. (2D)
Care Transformation	<p>The North Sound ACH will support implementation of prevention and health promotion strategies for targeted populations to prepare the region's providers for outcomes-based reimbursement, population health strategies, and addressing health disparities and achieve health equity.</p> <p>Strategies within this initiative will require the full engagement of traditional and nontraditional providers. Partners implementing these strategies will be supported through training in evidence-based approaches and best practices, as well as workforce development, HIT/HIE tools to connect clinical and community settings, technical assistance and training for billing and reporting on transformational care services, and other investments to support sustainable activities in this initiative.</p> <p>Project areas include:</p> <ul style="list-style-type: none"> • Addressing the Opioid Use Public Health Crisis (3A) • Reproductive and Maternal/Child Health (3B) • Access to Oral Health Services (3C) • Chronic Disease Prevention and Control (3D) 	3A, 3B, 3C, 3D	<ul style="list-style-type: none"> • Address the high rate of opioid use by supporting the implementation of the region's Opioid Plan with its goals to reduce opioid-related morbidity and mortality, targeting prevention, treatment, overdose prevention, and recovery supports. (3A) • Increase the number of people of reproductive age who have access to high quality reproductive health, support efforts that reduce unintended pregnancy, increase healthy planned pregnancies, strengthen and support young families, and promote early childhood health and well-being, setting the foundation for good health across the life course. (3B) • Increase access to oral health services by addressing barriers to care due to lack of capacity and location of care. (3C-access) • Support chronic disease prevention and control by integrating health system and evidenced-based community approaches to improve chronic disease prevention and management. (3D)
Care Integration	The North Sound ACH will support the integration of physical and behavioral health services through new care models, consistent with the state's path to fully integrated managed care by January 2020. As a 2019 mid-adopter region, the ACH is working in	2A, integration specific activities for 3A, 3B, 3C, 3D	<ul style="list-style-type: none"> • Support the bi-directional integration of physical and behavioral health. Bi-directional integration of care has the potential to impact all Medicaid enrollees in the North Sound ACH by targeting the expansion of

	<p>partnership with the North Sound BHO to evaluate, assist, and support the local physical and behavioral health systems transition toward integrated care.</p> <p>Strategies within this initiative will focus on innovative models of care that will improve the quality, efficiency, and effectiveness of care processes, and adoption of evidence-based standards of integrated care, such as co-location of providers and team-based approaches to care delivery that address physical, behavioral, and social barriers to improved outcomes for all populations with behavioral health needs.</p> <p>Partners will be supported in their integration activities through trainings in evidence-based models of integrated care, as well as ongoing practice coaching, learning collaboratives, population health management tools, and other clinical transformation supports.</p> <p>Project areas include:</p> <ul style="list-style-type: none"> • Bi-directional Integration of Care and Primary Care Transformation (2A) • Addressing the Opioid Use Public Health Crisis (3A) • Reproductive and Maternal/Child Health (3B) • Access to Oral Health Services (3C) • Chronic Disease Prevention and Control (3D) 		<p>health services to two key demographics—enrollees with behavioral health needs currently using the primary care system, and people with serious mental illness currently using the North Sound BHO system of behavioral health care. (2A)</p> <ul style="list-style-type: none"> • Address the capacity and protocols needed for bi-directional integration of care, by offering training to providers on how to adopt the required changes; and creating integrated care delivery protocols and models. (2A) • Ensure bi-directional partners are prepared for MCO payment changes by assessing partner readiness for MCO billing and invest in billing support for MCO billing. (2A) • Support care integration efforts that support upstream strategies for chronic disease prevention, maternal and child health, and access to oral health services, and strategies to address the opioid epidemic through the full engagement of traditional and nontraditional providers. (Integration specific activities for 3A, 3B, 3C, 3D)
Capacity Building	The North Sound ACH will create appropriate health systems capacity in order to expand effective community-based-treatment models; reduce unnecessary use of intensive services and settings without impairing health outcomes; and	Domain 1	<ul style="list-style-type: none"> • Support the state’s VBP goals by distributing VBP readiness tools and resources, connecting providers to state VBP training and technical assistance.

	<p>support prevention through screening, early intervention, and population health management initiatives.</p> <p>The North Sound ACH will support state Medicaid transformation efforts that contribute meaningfully to moving the state forward on VBP. Paying for value across the continuum of Medicaid services is necessary to assure the sustainability of the transformation projects undertaken through the Medicaid Transformation.</p> <p>Strategies within this initiative will addresses the core health system capacities to be developed or enhanced to transition the delivery system according to Washington’s Medicaid Transformation.</p> <p>Project areas include:</p> <ul style="list-style-type: none"> • Financial Sustainability - VBP • Workforce • Systems for Population Health Management 		<ul style="list-style-type: none"> • Promote a health workforce that supports comprehensive, coordinated, and timely access to care by assessing workforce readiness, capacity and needs. • Leverage and expand infrastructure for systems of population health management by assessing system use and barriers, current status of HIT and HIE and the interoperability capacity for community-based, integrated care. • Expand opportunities for clinical and community-based organizations to build a diverse workforce with shared lived experience between health workers and patients, while promoting the value of this workforce in driving health equity. • Embed health equity as a foundational element in its transformation strategy, supporting partners to implement strategies that will reach populations experiencing disparities in outcomes and access to move toward reaching universal goals of health and well-being.
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Attachment B: Crosswalk Required Milestones and Alternate Workplan Format

(Also included in the Workplan Excel file)

MINIMUM REQUIRED TOOLKIT MILESTONES (per ACH Implementation Plan Template update, 7/31/18)	IN NORTH SOUND ACH WORK PLAN (Alternative Format)
	Initiative, Row #
Project 2A: Bi-Directional Integration of Physical and Behavioral Health through Care Transformation	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Integration, Row 8 Capacity Building, Row 8
For 2020 adopters of integrated managed care: Ensure planning reflects timeline and process to transition to integration of physical and behavioral health including: engage and convene County Commissioners, Tribal Governments, Managed Care Organizations, Behavioral Health and Primary Care providers, and other critical partners. (Completion no later than DY 2, Q4.)	Did not include as it does not apply to North Sound region, as our region is a mid-adopter region in 2019
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols (Completion no later than DY 3, Q2.)	Care Integration, Row 17
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)	Care Integration, Row 24
Ensure each partnering provider and/or organization is provided with, or has secured, the training and technical assistance resources and HIT/HIE tools necessary to perform their role in the integrated care activities.	Care Integration, Row 63 Capacity Building, Row 13
- Obtain technology tools needed to create, transmit, and download shared care plans and other HIE technology tools to support integrated care activities. (Completion no later than DY 3, Q4.)	Capacity Building, Row 20
Provide participating providers and organizations with financial resources to offset the costs of infrastructure necessary to support integrated care activities. (Completion no later than DY 3, Q4.)	Capacity Building, Row 26
Stage 3: Scale & Sustain Milestones	
Increase use of technology tools to support integrated care activities by additional providers/organizations. (Completion no later than DY 4, Q4.)	Capacity Building, Row 59
Identify new, additional target providers/organizations. (Completion no later than DY 4, Q4.)	Care Integration, Row 73
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)	Care Integration, Row 81

Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.	
- Leverage regional champions and implement a train-the-trainer approach to support the spread of best practices. (Completion no later than DY 4, Q4.)	Care Integration, Row 77
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5 (Completion no later than DY 4, Q4.)	Care Integration, Row 87
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP (Completion no later than DY 4, Q4.)	Care Integration, Row 91
Project 2B: Community-Based Care Coordination	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Coordination, Row 8
Identify project lead entity, including:	
- Establish HUB planning group, including payers (Completion no later than DY2, Q4)	Care Coordination, Row 19
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)	Care Coordination, Row 24
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways. (Completion no later than DY 3, Q2.)	Care Coordination, Row 30
Implement project, which includes the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ:	n/a
- Create and implement checklists and related documents for care coordinators. (Completion no later than DY 3, Q4.)	Care Coordination, Row 41
- Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach. (Completion no later than DY 3, Q4.)	Care Coordination, Row 47
- Develop systems to track and evaluate performance. (Completion no later than DY 3, Q4.)	Care Coordination, Row 36
- Hire and train staff. (Completion no later than DY 3, Q4.)	Care Coordination, Row 49
- Implement technology enabled care coordination tools, and enable the appropriate integration of information captured by care coordinators with clinical information captured through statewide health information exchange. (Completion no later than DY 3, Q4.)	Care Coordination, Row 53
Develop description of each Pathway scheduled for initial implementation and expansion/partnering provider roles & responsibilities to support Pathways implementation. (Completion no later than DY 3, Q4.)	Care Coordination, Row 56
Stage 3: Scale & Sustain Milestones	

Expand the use of care coordination technology tools to additional providers and/or patient populations. (Completion no later than DY 4, Q4.)	Care Coordination, Row 99
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)	Care Coordination, Row 85
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)	Care Coordination, Row 93
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)	Care Coordination, Row 108
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)	Care Coordination, Row 112
Project 2C: Transitional Care	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Coordination, Row 8
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)	Care Coordination, Row 24
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways. (Completion no later than DY 3, Q2.)	Care Coordination, Row 30
Implement project, including the following core components across each approach selected:	n/a
- Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)	Care Coordination, Row 60 Capacity Building, Row 13
- Implement bidirectional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the electronic shared care plan). (Completion no later than DY 3, Q4.)	Care Coordination, Row 64
- Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)	Care Coordination, Row 69
- Incorporate activities that increase the availability of POLST forms across communities/agencies (http://polst.org/), where appropriate. (Completion no later than DY 3, Q4.)	Care Coordination, Row 74
- Develop systems to monitor and track performance. (Completion no later than DY 3, Q4.)	Care Coordination, Row 36
Stage 3: Scale & Sustain Milestones	

Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (Completion no later than DY 4, Q4.)	Care Coordination, Row 102
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)	Care Coordination, Row 85
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)	Care Coordination, Row 93
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)	Care Coordination, Row 108
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)	Care Coordination, Row 112
Project 2D: Diversion Interventions	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Coordination, Row 8
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols. (Completion no later than DY 3, Q2.)	Care Coordination, Row 24
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches/pathways. (Completion no later than DY 3, Q2.)	Care Coordination, Row 30
Implement project, including the following core components across each approach selected:	n/a
- Ensure participating partners are provided with, or have access to, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)	Care Coordination, Row 60
- Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure team members, including client, have access to the information appropriate to their role in the team). (Completion no later than DY 3, Q4.)	Care Coordination, Row 64
- Establish mechanisms for coordinating care management plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)	Care Coordination, Row 69
Stage 3: Scale & Sustain Milestones	
Expand the model to additional communities and/or partner organizations. (Completion no later than DY 4, Q4.)	Care Coordination, Row 105
Employ continuous quality improvement methods to refine the model, updating the model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)	Care Coordination, Row 85

Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)	Care Coordination, Row 93
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)	Care Coordination, Row 108
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)	Care Coordination, Row 112
Project 3A: Addressing The Opioid Use Public Health Crisis	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Transformation, Row 8
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)	Care Transformation, Row 17
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)	Care Transformation, Row 23
Implement selected strategies/approaches across the core components: 1) Prevention; 2) Treatment; 3) Overdose Prevention; 4) Recovery Supports. (Completion no later than DY 3, Q4.)	Care Transformation, Row 42
Monitor state-level modifications to the 2016 Washington State Interagency Opioid Working Plan and/or related clinical guidelines, and incorporate any changes into project implementation plan. (Completion no later than DY 3, Q4.)	Care Transformation, Row 50
<p>Convene or leverage existing local partnerships to implement project, one or more such partnerships may be convened. (Completion no later than DY 3, Q2.)</p> <ul style="list-style-type: none"> - Each partnership should include health care service, including mental health and SUD providers, community-based service providers, executive and clinical leadership, consumer representatives, law enforcement, criminal justice, emergency medical services, and elected officials; identify partnership leaders and champions. Consider identifying a clinical champion and one or more community champions. - Establish a structure that allows for efficient implementation of the project and provides mechanisms for any workgroups or subgroups to share across teams, including implementation successes, challenges and overall progress. - Continue to convene the partnership(s) and any necessary workgroups on a regular basis throughout implementation phase. 	Care Transformation, Row 53
Develop a plan to address gaps in the number or locations of providers offering recovery support services, (this may include the use of peer support workers). (Completion no later than DY 3, Q4.)	Care Transformation, Row 59
Stage 3: Scale & Sustain Milestones	

Increase scale of activities by adding partners and/or reaching new communities under the current initiative (e.g. to cover additional high needs geographic areas), as well as defining a path forward to deploy the partnership's expertise, structures, and capabilities to address other yet-to-emerge public health challenges. (Completion no later than DY 4, Q4.)	Care Transformation, Row 117
Review and apply data to inform decisions regarding specific strategies and action to be spread to additional settings or geographical areas. (Completion no later than DY 4, Q4.)	Care Transformation, Row 139
Provide or support ongoing training, technical assistance, and community partnerships to support spread and continuation of the selected strategies/approaches. (Completion no later than DY 4, Q4.)	Care Transformation, Row 108
Convene and support platforms to facilitate shared learning and exchange of best practices and results to date (e.g., the use of interoperable HIE by additional providers providing treatment of persons with OUD). (Completion no later than DY 4, Q4.)	Care Transformation, Row 135
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)	Care Transformation, Row 131
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)	Care Transformation, Row 145
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)	Care Transformation, Row 149
Project 3B: Reproductive and Maternal/Child Health	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Transformation, Row 8
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)	Care Transformation, Row 17
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)	Care Transformation, Row 23
Implement project, including the following core components across each approach selected:	n/a
- Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)	Care Transformation, Row 35 Capacity Building, Row 13
- Implement bi-directional communication strategies/interoperable HIE tools to support project priorities (e.g., ensure care team members, including client and family/caregivers, have access to the care plan). (Completion no later than DY 3, Q4.)	Care Transformation, Row 64

- Establish mechanisms, including technology-enabled, interoperable care coordination tools, for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs. (Completion no later than DY 3, Q4.)	Care Transformation, Row 73
- Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes. (Completion no later than DY 3, Q4.)	Care Transformation, Row 29 Care Integration, Row 32
Stage 3: Scale & Sustain Milestones	
Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (Completion no later than DY 4, Q4.)	Care Transformation, Row 112
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)	Care Transformation, Row 103
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)	Care Transformation, Row 108
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)	Care Transformation, Row 145
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)	Care Transformation, Row 149
Project 3C: Access to Oral Health Services	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Transformation, Row 8
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols. (Completion no later than DY3, Q2.)	Care Transformation, Row 17
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)	Care Transformation, Row 23
Implement project, including the following core components across each approach selected:	n/a
- Implement bi-directional communications strategies/interoperable HIE tools to support the care model. (Completion no later than DY 3, Q4.)	Care Transformation, Row 64
- Establish mechanisms for coordinating care with related community-based services and supports. (Completion no later than DY 3, Q4.)	Care Transformation, Row 107
- Develop workflows to operationalize the protocol, specifying which member of the care team performs each function, inclusive of when referral to dentist or periodontist is needed. (Completion no later than DY 3, Q4.)	Care Integration, Row 55

- Establish referral relationships with dentists and other specialists, such as ENTs and periodontists. (Completion no later than DY 3, Q4.)	Care Integration, Row 59
- Ensure each member of the care team receives the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. (Completion no later than DY 3, Q4.)	Care Transformation, Row 35 Capacity Building, Row 13
- Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes. (Completion no later than DY 3, Q4.)	Care Transformation, Row 29 Care Integration, Row 30
- Engage with payers in discussion of payment approaches to support access to oral health services. (Completion no later than DY 3, Q4.)	Capacity Building, Row 36
Stage 3: Scale & Sustain Milestones	
Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities. (Completion no later than DY 4, Q4.)	Care Transformation, Row 112
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)	Care Transformation, Row 103
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion. (Completion no later than DY 4, Q4.)	Care Transformation, Row 108
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)	Care Transformation, Row 145
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)	Care Transformation, Row 149
Project 3D: Chronic Disease Prevention and Control	
Stage 1: Planning Milestones	
Identify work steps and deliverables to implement the transformation activities and to facilitate health systems and community capacity building (HIT/HIE, workforce/practice transformation, and value-based payment), and health equity. (Completion no later than DY 2, Q3.)	Care Transformation, Row 8
Stage 2: Project Implementation Milestones	
Develop guidelines, policies, procedures and protocols. (Completion no later than DY 3, Q2.)	Care Transformation, Row 17
Develop continuous quality improvement strategies, measures, and targets to support the selected approaches. (Completion no later than DY 3, Q2.)	Care Transformation, Row 23
Implement disease/population-specific Chronic Care Implementation Plan for identified populations within identified geographic areas, inclusive of identified change strategies to develop and/or improve: <ul style="list-style-type: none"> - Self-Management Support - Delivery System Design - Decision Support - Clinical Information Systems (including interoperable systems) - Community-based Resources and Policy 	Care Transformation, Row 83

- Health Care Organization (Completion no later than DY 3, Q4.)	
Implementation should ensure integration of clinical and community-based strategies through communication, referral, and data sharing strategies. (Completion no later than DY 3, Q4.)	Capacity Building, Row 40
Stage 3: Scale & Sustain Milestones	
Increase scale of approach, expand to serve additional high-risk populations, include additional providers and/or cover additional high needs geographic areas, to disseminate and increase adoption of change strategies that result in improved care processes and health outcomes. (Completion no later than DY 4, Q4.)	Care Transformation, Row 122
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required. (Completion no later than DY 4, Q4.)	Care Transformation, Row 103
Provide or support ongoing training, technical assistance, learning collaborative platforms, to support shared learning, spread and continuation, and expansion of successful change strategies (e.g., the use of interoperable Clinical Information Systems by additional providers, additional populations, or types of information exchanged). (Completion no later than DY 4, Q4.)	Care Transformation, Row 127
Identify and encourage arrangements between providers and MCOs that can support continued implementation of the Project beyond DY 5. (Completion no later than DY 4, Q4.)	Care Transformation, Row 145
Identify and resolve barriers to financial sustainability of Project activities post-DSRIP. (Completion no later than DY 4, Q4.)	Care Transformation, Row 149